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SUPPORTING DESERT SHIELD:
AN ANALYSIS OF THE RESPONSE BY THE UNITED
STATES ARMY MEDICAL DEPARTMENT ACTIVITY, FORT STEWART,
TO RADICAL ENVIRONMENTAL CHANGE

A Graduate Management Project
Submitted to the Faculty of
Baylor University
in Partial Fulfillment of the
Requirements for the Degree
of
Master of Health Administration
by
Captain John D. Quinlivan, MS
May 1991

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Abstract

On August 2, 1991, Iraq invaded neighboring Kuwait. Within a week of the invasion, the United States had begun troop deployments to the region to defend Saudi Arabia from further Iraqi aggression. The operation, code named "Desert Shield," would ultimately involve half a million American troops, among them, the 18,000 soldiers of the 24th Infantry Division from Fort Stewart, Georgia. This study discusses the deployment of the 24th Division and its impact on the United States Medical Department Activity (MEDDAC) at Fort Stewart.

The deployment of the 24th Division marked the first full-scale deployment of a heavy Army division since the Korean War. The MEDDAC's support of that deployment and of subsequent reserve mobilizations and deployments presented many unique situations. A number of these situations are discussed in this study, including: employment of the Professional Officer Filler System (PROFIS), use of "backfill" physicians, integration of an Army Reserve augmentation hospital, medical support of Soldier Readiness Processing (SRP), conduct of deployability medical evaluations, and the activities of various elements of the MEDDAC staff in support of Operation Desert Shield.

Operation Desert Shield imposed a period of radical change upon the Fort Stewart community and the USA MEDDAC. The literature indicates that organizations best respond to change by assuming adaptive characteristics such as information openness, participative leadership, and innovation. The MEDDAC did not exhibit these characteristics. Rather, it tightened control, stifling communication and participation. Relying upon the authoritarian leadership of its Commander, however, the MEDDAC performed exceptionally well in support of Operation Desert Shield. The MEDDAC's model performance implies that the literature on organizational response to change is not applicable to a scenario such as that presented by Operation Desert Shield.

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SECTION 1: A Theoretical Basis for the Study

I. Introduction

Iraq invaded neighboring Kuwait on Thursday, August 2, 1991. The invasion came after Iraq had massed thousands of troops and hundreds of tanks on the Kuwaiti border. Iraqi ground troops, supported by helicopters, jets and artillery, crossed into Kuwait in the pre-dawn hours and by mid-morning had reached the capital, Kuwait City. Kuwait's small army was grossly outnumbered and quickly crushed. By evening, the takeover was complete with Iraqi troops in control of every government building in Kuwait City. (Salome and Alexander, 1990).

The international reaction to the invasion was uniformly negative, though not completely consistent. The Arab nations were initially cautious. The Arab League Council, meeting in emergency session, did not immediately condemn Iraq's action. Nor did any Arab government officially condemn the invasion. However, the West was less reticent. The United States immediately renounced Iraq's "naked aggression" toward its neighbor. The United Nations Security Council met in emergency session and voted unanimously to condemn

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the invasion. Great Britain, France, Japan, and even the Soviet Union responded similarly, each imposing economic sanctions on Iraq. (Dalglish, 1990).

International options for responding to Iraq's invasion of Kuwait were limited. Iraq's military, estimated at the fourth largest in the world, was superior to any in the region (Salome and Alexander, 1990). The United States had only a small naval force in the Persian Gulf and no ground troops in the immediate area. Consequently, the initial responses consisted of suspending trade, freezing Iraqi and Kuwaiti assets, and veiled threats of military intervention.

As days passed it became clear that, contrary to its promises, Iraq had no intention of leaving Kuwait. International opposition to Iraq's aggression began to grow. Calls for Iraq's withdrawal from Kuwait now came not only from the west, but also from Israel, the Soviet Union, and the Arab nations of Saudi Arabia, Egypt, Syria, and Iran.

Saudi Arabia, recognizing the threat posed by Iraq, requested American military assistance. On Wednesday, August eighth, the first American Army troops began arriving in Saudi Arabia. Air Force F-15

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and F-111 aircraft were simultaneously deployed (Associated Press, August 10, 1990). Other NATO countries quickly followed suit sending their troops to join the fledgling military coalition.

While Secretary of State James Baker endeavored to generate unified worldwide opposition against Iraq, some members of the American Press began questioning American motives. Some alledged that, rather than punishing aggression, the United States was more interested in holding down oil prices (Grady, 1990). Such assertions fueled the "no blood for oil" demonstrations which began shortly after the initiation of military deployments to the region.

On Thursday, August ninth, Iraq further angered the world when it announced that foreigners in Iraq would not be permitted to leave. Hundreds of American citizens were among those held hostage under this decree (Alexander and Salome, 1990, Atlanta). Meanwhile, the fate of thousands of other Americans in Kuwait was unknown.

Egyptian President Mubarak emerged from the Arab peace conference on Saturday, August eleventh, announcing that he saw no hope for a peaceful resolution to Iraq's occupation of Kuwait. He

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indicated that Egypt would send troops to Saudi Arabia to join those of other nations currently arrayed against an Iraqi attack. Indications were that other Arab nations including Syria, Morocco, Oman, Bahrain and the United Arab Emirates were also set to send troops to Saudi Arabia. As if to underline the growing seriousness of the situation, Saudi air-defense forces fired on two Iraqi jets later that day. (Albright and Salome, 1990).

The American commitment to the defense of Saudi Arabia continued to be in evidence as elements of the 1st Marine Expeditionary Force and the Army's 101st Airborne Division joined elements of the 82nd Airborne Division in the desert country. The Pentagon indicated that many other units, including the 24th Infantry Division (Mechanized), were preparing for deployment. It was reported that contingency plans for the operation, now code-named "Desert Shield," called for the deployment of as many as 250,000 American ground troops. (Associated Press, August 12, 1990).

The soldiers and families of Fort Stewart, Georgia watched the evolving Persian Gulf situation closely. The 24th Division was put on alert on August 6th. Twenty fourth Division officials announced that the

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alert was simply a routine Emergency Deployment Readiness Exercise (EDRE). However, the members of the Fort Stewart community knew better. Rumors of a potential division deployment began shortly after the outbreak of hostilities. The announced EDRE simply confirmed these rumors.

The EDRE touched off a period of frenzied activity at Fort Stewart, particularly within the 24th Division. All soldiers were called in as leaves and passes were cancelled. The Division began round-the-clock operations. It was readily evident that this was no mere exercise.

After watching their husbands or wives leave home on August 6th, family members began to fear they would not see them again. As the seriousness of the situation sunk in, a paranoia--for some, panic--developed. Across the installation, young wives lined up along the fences surrounding battalion motor pools. They were there for a final glimpse of their loved ones, perhaps a hug and a kiss goodbye.

In the days immediately following the alert, it appeared that the division would depart very rapidly. Certainly the soldiers seemed to expect an immediate departure. Deployment preparations proceeded at a

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tremendous pace, often in a seemingly haphazard manner. In most cases, soldiers stayed in their unit areas working night and day to meet an unknown deadline.

While the pre-deployment work continued, the 24th Division Commander, Major General Barry McCaffrey, took the time to meet with the spouses of his soldiers on August 8th. He provided what little information he could and tried to lessen the paranoia. He also formally called on the spouses to establish "chains of concern" in order to help each other. Mrs. McCaffrey was very much a part of this meeting and would become a key leader and role-model for spouses of deployed soldiers.

There was a great deal of uncertainty throughout the pre-deployment period and especially during the initial days following the alert. The timing of the actual deployment was the biggest unknown. At first, it seemed the division would begin leaving almost immediately. The initial flurry of activity was in preparation for rail movement to the port of Savannah. The division was set to begin this move in a matter of days. However, the constraint was availability of ships. It soon became evident that the Military Sealift Command would require more than a few days to

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get a dozen heavy container ships to the port. Once loaded, it would take almost three weeks for these ships to make the voyage across the Atlantic.

It would be incorrect to say the pace slowed when the division realized the deployment would not occur immediately. The rapid pace of activity continued but it became a bit more orderly. Unit commanders seemed to realize they had time to follow their deployment plans, which were based upon a time-line longer than a few days. Pre-deployment operations settled into something of an intense routine. Equipment and supplies were not loaded quite so haphazardly now. Actions were more deliberate and evidenced greater forethought. The division began to move purposely toward a more clear objective.

As units neared their rail-load dates, they were moved out of their garrison location to secure confinement areas elsewhere on post. From this time until the rail load was complete (generally a period of 48 to 72 hours), the unit was "locked-in." Soldiers assumed a semi-tactical posture and reportedly live munitions were issued. If any doubt remained, it was now put to rest; the 24th Division was going to war.

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Conditions Which Prompted the Study

As events unfolded in the Middle-East and the 24th Division prepared for deployment, the Army MEDDAC at Fort Stewart found that it too had a significant role to play. That role, or more specifically the manner in which that role was played out, is the subject of this paper. Activities of the MEDDAC during the pre-deployment, post-deployment, and reserve mobilization phases of Operation Desert Shield will be explored. The MEDDAC's actions will be analyzed in terms of its responsiveness to the dramatic change brought about by the operation.

Statement of the Research Question

How does the change-responsive status of the Army MEDDAC at Fort Stewart, Georgia influence the MEDDAC's ability to accomplish its mission during a time of significant environmental change brought about by an event such as Operation Desert Shield?

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II. Organizational Change: A Review of the Literature

All organizations face change. The degree of change and the pace at which change proceeds may be factors of a number of variables. Among these variables are: key organizational processes, the external environment, employees and other tangible assets, formal organizational arrangements, the internal social system, the organization's technology, and the dominant coalition. Kotter (1978) identified these elements in a model of organizational dynamics. Kotter's model serves as an excellent vehicle for examining organizational change. Before pursuing this model further, it is necessary to understand change and its implications for an organization.

Change is defined as "the process or result of alteration or modification; a transation from one state to another" (The American Heritage Dictionary, 1982). While this seems an easy concept to grasp, there exists considerable disagreement as to how change occurs in an organization. March (1981) depicts change as a continuous organizational process; something inherent to the daily functioning of the firm. Others hold that change occurs in brief episodes interspersed between long periods of stability and inertia (Miller

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and Friesen, 1984). While Levitt (1989) believes change comes about quietly, Meyer (1982) holds that change results from unforeseen exogenous shocks. Obviously, these are views of change in its noun form: As something which happens to, or occurs within an organization. This passive view of change is expressed well by Altany (1989) who maintains that willing or unwilling, change will come.

A more active view is taken by those who advocate change in the form of organizational development or OD. Burke and Schmidt (1971) define organizational development as:

A process which attempts to increase organizational effectiveness by integrating individual desires for growth and development with organizational goals. Typically, this process is a planned change effort which involves a total system over a period of time, and these change efforts are related to the organization's mission. In this context, change is regarded as something to do: to change; to rearrange organizational structures or processes, or both, to bring about a new, higher level of performance.

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The shift from a passive to a more active view of change is evident in the evolution of modern management practice. In the early part of this century, Taylor, Fayol, Weber, and others emphasized the importance of design and control in what we would now call homeostatic organizations. These organizations ran by the book and made changes very slowly. Adaptive management, introduced later in the century, recognized the need for organizational responses to changing environments. In recent years, environmental change has steadily accelerated. This modern evolutionary period has been referred to as the Age of Restructuring (Winston, 1990). In this age, organizations recognize the need to tie organizational change efforts (OD) with changes in their environment. The ability to live with, control, and even welcome much higher rates of change has now become essential. (Skibbens, 1974).

The Role of Change in Organizational Evolution

A new perspective of change is also evident in the evolving nature of organizational structures. Early in the century, Taylor's theories of scientific management were ideal for the hierarchical organizational structures and bureaucratic processes then in use. These concepts resulted in mechanistic organizations

which resisted change and emphasized consistent, predictable organizational performance. Mechanistic organizations were appropriate in this period of relatively static organizational environments. However, as the rate of change in the environment accelerated, the mechanistic form became increasingly restrictive (Skibbens, 1974). Organizations then found it necessary to open themselves to their environments in order to meet change with change. There was a shift from the restrictive mechanistic form to an organic organizational form. The organic organization relies upon individuals with specialized knowledge and recognizes unique individual capabilities (Basil and Cook, 1974). The key task in these organic organizations is not to design the most elegant organizational structure but to capture individual capabilities and motivate the entire organization to respond cooperatively to a complicated and dynamic environment (Bartlett and Ghoshal, 1990).

Change and the Organizational Environment

Before proceeding further, it is helpful to understand the meaning of the term organizational environment. The environment, in its broadest sense, is everything external to the organization's boundaries

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(Szilagyi and Wallace, 1984). A more narrow view of the organizational environment can be achieved by distinguishing between the general environment of the organization and the organization's specific task environment (Dill, 1958). The general environment consists of political, economic, resource, social, and technological components which effect all organizations to differing degrees. An organization's task environment consists of a more specific set of factors which directly impact the internal functioning of the organization. The task environment can be further subdivided along the dimensions of change and complexity (Duncan, 1972). The degree of change refers to the extent to which an organization's task environment is either static or dynamic. Complexity is determined by the number of components in an organization's task environment.

Environmental uncertainty arises when the general environment changes and the task environment becomes more dynamic and complex. Under such conditions, characterized by a lack of information about the environment and lack of knowledge about results of

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certain organizational actions, decision making becomes a highly uncertain process. (Hrebiniaik and Snow, 1980; Leblebici and Salancik, 1981).

Recognition of the interrelatedness of an organization and its environment fueled the shift from static to change-responsive organizations. The belief that organizational performance is somehow contingent upon a congruence between organizational characteristics and the environment is a basic tenet of modern organizational theory (Burns and Stalker, 1961; Lawrence and Lorsch, 1967; Child 1972).

To better understand change and its active and passive natures, one must recognize the organization's direct relationship with its environment. As environmental changes occur, the organization responds by initiating internal change. Thus, passive change--that is environmental change-spurs active change within the organization.

Types of Change

All change is either planned or unplanned. Active change programs reflect the application of planned change. Inadvertent change can also be planned if it is anticipated. Dilenschneider and Hyde (1985) argue that unplanned change can be reduced by identifying

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potential crisis situations, measuring the impact of such crises, and identifying those responsible for dealing with them. Such contingency plans should be written and made available to all members of the organization.

If change is to be planned, it must be anticipated. Organizations better anticipate change when they assume an adaptive strategy, increasingly searching their environment for potential change (Lant and Mezias, 1990). They must, therefore, create a psychological climate which allows for adaptation and change (Hornstein, 1986). These actions are more easily accomplished in a fully organic organization: One which has replaced the typical hierarchical structure with a network arrangement of information systems (Pascarella, 1989). The organic organization relies upon the talents of its members. It closely monitors the environment for signs of change and seeks to adopt innovative responses based upon the input of its experts--its employees.

The goals of planning for change are to reduce or eliminate the amount of change which is totally unexpected, to accurately project the impact of changes which are anticipated, and to better enable the

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organization to adapt to changes which are unexpected. Contingency planning is a familiar method of identifying and planning for potential change. To correctly anticipate change, however, it may be necessary to revise organizational structures or processes, or both. Restructuring an organization, or modifying its processes, can help an organization respond to unexpected environmental changes (McHale, 1969).

While a fully organic organization appears to be the most desirable in terms of change-responsiveness, it is seldom achieved. As Basil and Cook (1974) note: "Few organizations have begun to approach the responsive-proactive ideal. They are engulfed in a system that perpetuates conformity, precedent, and procedure and allows past commitments to bear heavily on current decisions."

It is possible that dramatic change can drive organizations toward the ideal to which Basil and Cook refer. Dramatic change, or radical change, can be deliberately introduced as a planned program designed to revitalize an organization, or it can be totally unexpected. Such change has the potential to spur effective organizational development (Hall, 1985).

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Recognition of this potential led Skibbens (1974) to proclaim that "radical change opens the door to a much higher level of profitability and reward." Anderson (1990) echoes this sentiment saying, "if turbulence can wreak havoc, it can also uncover hidden treasures."

Dramatic change has also been referred to as discontinuous change. It is different from continuous or first-order change which occurs within a stable system that itself remains unchanged. Discontinuous or second-order change transforms fundamental properties or states of the system. (Watzlawick, Weakland, and Fisch, 1974).

The result of discontinuous change occurring at the industry level is revolutionary change. Revolutionary change is a restructuring or reconstituting of the industry brought about by repetitive discontinuous changes. Revolutionary change often creates environmental jolts which provoke crises within organizations. These crises can facilitate organizational change and development. As organizations respond to the crises wrought by revolutionary change, they often experiment with new

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organizational forms. They also seek to establish interorganizational networks to absorb uncertainty. (Meyer, Brooks, and Goes, 1990).

Resistance to Change

Although now widely recognized as a potentially positive event, change is often resisted. This seems paradoxical, but may be a natural organizational (and human) reaction. Organizations are created and function in a stable environment. Change in the environment forces the organization to change its comfortable, familiar mode of operation for one more conducive to the new environment (Lant and Mezias, 1990).

Organizational resistance to change can be reinforced by external systems. "Any organization has a network of external systems (e.g., customers, suppliers, communities) affecting it. Most of these external systems keep it operating today as it did yesterday--for their convenience" (Skibbens, 1974).

Resistance to change is influenced by a number of factors. Organizations which face little or no competition generally encounter a greater degree of resistance to change than do those in highly competitive markets (Kotter, 1978). Government

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organizations are often less receptive to change than are nongovernment organizations (Brown, 1980). Large organizations, due to their tremendous bulk, have more difficulty adapting to change than do small organizations (Levitt, 1988).

Change is difficult to implement in any organization. This is partly due to the interrelatedness of organizational elements. Change in any part of a system will have repercussions for other parts of the system (Anderson, 1990). This is clearly depicted in Kotter's (1978) model which was discussed briefly at the beginning of this paper. The notion that change in one element of a system creates a need for change in another will be revisited.

Kotter and Schlesinger (1979) contend that the constraints to change can be grouped in three categories: Leadership climate, formal organizational design, and individual characteristics. They identify leadership climate as the atmosphere in the work environment that results from the leadership style and administrative practices of the top executives. Formal organizational design can impede change by restricting access to information, blocking communication, and reinforcing old organizational norms. Individual

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characteristics important to change and development programs include learning abilities, attitudes, personality, and expectations.

Change is resisted by individuals within organizations for many reasons. Kotter (1990) contends organizations have difficulty adapting to change because people feel relatively powerless. Szilagyi and Wallace (1983) argue that change often creates resistance by the manner in which it is introduced, the magnitude of the change, and the change itself. They identify specific areas of resistance as: Fear of economic loss, potential for social disruption, inconvenience, fear of uncertainties, and resistance from groups.

Overcoming Resistance to Change

Successfully overcoming resistance to change requires that organizations focus their attention in four key areas: leadership, communication, participation, and innovation. Of these, leadership is most important. Leadership skill is essential in times of significant external change (Motzer and Boissoneau, 1989). Organizational leaders must recognize the need

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for change and show commitment, open-mindedness, and a willingness to challenge traditional assumptions (Hall, 1985).

Leadership may be best understood by considering a number of definitions. Szilagyi and Wallace (1983) hold that "leadership is a process concerning the relationship between two or more people in which one attempts to influence the other toward the accomplishment of some goal or goals." Koontz and O'Donnell (1976) offer a complimentary definition of leadership as "the art or process of influencing people so that they will strive willingly toward the achievement of group goals." In a more earthy tone, Harry Truman said, "leadership is the ability to get other people to do what they don't want to do and like it" (Labich, 1988). Winston Churchill takes Truman's definition a step further maintaining that leadership involves getting ordinary people to do extraordinary things in the face of adversity (Grove, 1988). McConnell (1983) holds that leadership involves such intangible characteristics as honesty, integrity, and initiative. However, he contends the single factor which defines or characterizes leadership is acceptance of followers.

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The study of leadership focuses on identifying the factors which result in leader effectiveness. Three well-known groupings of leadership theories are: Trait theories, behavioral theories, and situational theories. Trait theories, popular during the 1940s and 1950s, held that a finite set of traits or characteristics could be used to distinguish successful from unsuccessful leaders. Behavioral theories became popular in the 1950s and held that successful leaders could be distinguished from unsuccessful leaders according to their particular style of leadership. Leadership styles were typically classified as either task oriented or employee oriented. However, the determination that neither task orientation nor employee orientation proved successful in all situations led to the development of situational theories in the late 1960s. Situational theories held that the effectiveness of the leader is not only determined by his style of behavior, but also by the situation surrounding the leadership environment. Situational factors include the characteristics of the leader and the subordinate, the nature of the task, the structure of the group, and the type of reinforcement. (Szilagyi and Wallace, 1983).

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Fiedler (1967) developed one of the first situational models of leadership. His theory is founded on the belief that leader effectiveness is contingent on the need structure of the leader and the degree to which the leader has control and influence in a particular situation. His framework involves leadership-style assessment, task structure, group atmosphere, and the leader's position power. Fiedler's Contingency Model analyzes these factors and generates a recommended leadership style, task-centered or employee-centered, for a given situation. (Szilagyi and Wallace, 1983).

The path-goal theory of leader effectiveness is another situational theory of leadership. In expressing the premise of the path-goal theory, House (1971) maintains:

The motivational function of the leader consists of increasing personal payoffs to subordinates for work-goal attainment, and making the path to these payoffs easier to travel by clarifying it, reducing roadblocks and pitfalls, and increasing the opportunities for personal satisfaction en route.

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According to the path-goal theory, the leader must focus on clarifying the links between employee effort, performance and reward thereby increasing employee expectancy, instrumentality, and valence perceptions. The theory recognizes the role of the leader and the dynamics of the situation as key factors in leadership effectiveness. (Szilagyi and Wallace, 1983).

Leadership style or behavior plays an important role in both situational theories discussed above. Skibbens (1974) holds that there are at least five modes of leader behavior. In his description of the types of leader behavior, he notes:

In authoritarian leadership, a single individual dictates policy arbitrarily. In democratic leadership the group discusses each matter and reaches a decision with only the guidance of the leader. In laissez faire leadership the group is left completely on its own without even the advice of the leader. Bureaucratic leadership in effect substitutes a rule book for an autocratic leader. Decisions are dictated not by the leader, but rather by a formal code of regulations or

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procedures. Finally, neurocratic leadership refers to an autocratic mode wherein the leader acts from a neurotic compulsion to lead.

Many suggest that the typical view of leadership is changing. Kanter (1989) maintains that as ways to combine resources increase, the ability to command diminishes. She believes that alternative paths to communication, resource access, and execution erode the authority of those in the nominal chain of command and force managers to exercise more leadership.

Leadership, in this context, involves spending more time on cross-boundary relationships and delegating more responsibility to lower level managers.

The new view of leadership involves open communication, participative management, and innovation. "The management command and control structure, with virtually all authority and responsibility residing in a chief executive at the top of the management pyramid, is fast giving way" (Labich, 1988). Leaders must encourage controversy and entertain sharply differing opinions as a way of improving decisions.

It is particularly important that top-level executives understand and appreciate the new view of

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leadership. The higher a manager rises in an organization, the more difficult it becomes to stay in touch with the things about which decisions must be made (Levitt, 1988). As Labich (1988) points out, "the higher you get in an organization, the more important it is to have people who will tell you when you are right or wrong."

Much controversy exists over the distinction between managers and leaders, and change appears to be the differentiating factor. Management involves coping with complexity; leadership is about coping with change. Both are necessary in today's organizations. Companies manage complexity by planning, budgeting, and organizing resources. By contrast, leading an organization to constructive change begins by setting a direction, developing a vision for the future. Setting the direction of change is fundamental to leadership. (Kotter, 1990).

Vision is a critical element of leadership. It is the means through which the leader articulates the desired future of the organization. Visionary leadership, rather than management skills, will be the key to success in the future (Pasarella, 1989). As members of the organization come to understand and

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share the leader's vision they become inspired. The vision must be retranslated to each separate employee group through concrete objectives (Altany, 1989).

Translating the leader's vision requires effective, open communication. Effective communication is the cornerstone for developing a smooth process of organizational change (MacStravic, 1984). Skibbens (1974) argues the clear communication of objectives is essential as the organization strives to realize its desired future. Objectives must be specific and understandable, they should be quantifiable in both time and space, and they should be realistic. Objectives which meet these standards will reduce or eliminate misunderstandings between managers of different operating units who often see organizational objectives differently (Bartlett and Ghoshal, 1990).

Effective communication goes beyond simply articulating objectives and issuing plans. Communication must be typified by complete information openness if radical change is to succeed (Skibbens, 1974). Companies should make a special effort to see that even in the midst of a crisis people feel free to

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voice objections (Hornstein, 1986). It is only in such an environment that truly successful organizational change efforts can be carried out.

Radical change requires open communication. Decisions must be clearly expressed, accurately transmitted, and perfectly understood (Dilenschneider and Hyde, 1985). To achieve radical change, levels of knowledge much greater than those needed to run the system must be added. Contacts must be established between members of the organization and outside experts in order to update techniques and procedures. An intelligence center should be established to collect and assemble information so that managers and employees can easily access the information needed to continue the change process. (Skibbens, 1974)

Communication must be scrutinized during periods of change. Research findings indicate that people consistently overrate their own communication abilities when compared to assessments by their peers, subordinates, and superiors (Sypher and Sypher, 1984). Distorted communication causes great confusion and often results in the wrong information being transmitted (Motzer and Boissoneau, 1989).

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Credibility of the sender greatly influences the manner in which information is received. Among the factors which influence credibility are: the track record of the person delivering the message, the content of the message itself, the communicator's reputation for trustworthiness and integrity, and the consistency between words and deeds (Kotter, 1990).

Open communication encourages greater employee participation in the operation of the organization. This is a desirable occurrence, particularly during times of organizational change. It is now widely recognized that people will be more likely to adopt a change if they can help to design it (Skibbens, 1974). Such employee involvement requires participative management (Labich, 1988). Koontz and O'Donnell (1976) describe participative management as a situation in which:

The manager is strongly oriented to subordinates, relying on communication to keep all parties working as a unit. All members of the group, including the manager or leader, adopt a supportive relationship in which they feel a genuine common interest in terms of needs, values, aspirations, goals, and expectations.

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Rensis Likert and his associates noted that managers who used a participative approach were more effective in achieving goals. Likert ascribed this to the extent of participativeness in management and the extent to which the practice of supportive relationships is maintained. (Koontz and O'Donnell, 1976).

Support for participative management as an effective management strategy has grown as environmental change accelerates. Organizations need the synergy that can come from getting more people involved in the decision making process (Pascarella, 1989). Traditional rules, procedures, and hierarchies stifle the information flow necessary to make the rapid decisions required by a fast-changing environment. Decentralization speeds organizational responses to change by dispersing decision-making authority to lower levels in the organization (Anderson, 1990). Participative management and decentralized decision making require that leaders hold firm expectations of their employees so as not to question them at every sign of poor performance. Leaders must learn to tolerate some mistakes to provide ground for growth (Field, 1989). They must accept the fact that in most

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cases the people who are actually doing a job, who are closest to the work, know more about it than do their managers (Winston, 1990).

Participative management can be extended to the highest echelons of an organization. Taking this to the extreme, Frederick Thayer argues that we should do everything we can to diminish the unilateral authority of anybody who is in charge of anything (Pasarella, 1989). Gilmore (1990) maintains that groups are more effective than a single individual at leading an organization through a changing environment. He believes groups have a greater ability to make sense of what is going on and are thus more adaptive to change. Peters and Tseng (1984) note that leadership teams can be most effective at sensing the need for change, identifying new directions, and establishing a process to achieve the goal.

Increased innovation can result from employee participation and open communication. New ideas are essential to the organization's ability to cope with change. The best solutions frequently come from people other than those immersed in the daily grind of trying

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to work out a problem. Therefore, it is important to allow participation and solicit input from all levels of the organization. (Skibbens, 1974).

Innovation may become more difficult during the turbulence of environmental change and organizational crisis. But, it is during times of crisis that organizations must make special efforts to encourage and protect the flow of innovative ideas (Hornstein, 1986). Organizations must maintain a psychological climate that allows for adaptation and change. Such a climate as described by Hill (1989) is one in which:

Leaders encourage their employees to be innovative, and trust them implicitly in their areas of competence. They readily acknowledge that the real experts in any area are those actually performing the work. They encourage risk taking and accept failures as steps in the process of growth and development.

Unfortunately, just when openness--leadership, communication, participation, and innovation--is most needed, some organizations respond by tightening the reins. As Hornstein (1986) notes:

Too often executives react to hard times by hunkering down protectively and acting as if

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nothing has changed. Worse, they start to practice what I call "ideacide," rejecting new ideas out of hand without adequate consideration or analysis. At a time when courage and innovation are most needed to shake out of a business slump, they hope that doing business as usual will produce business as usual.

In one of many leader-manager contrasts, Hill (1989) claims, "managers believe crises require them to reestablish who is in charge and to aggressively direct the people in the organization to elicit the performance they want." He continues noting that, "managers as they have been taught, ask subordinates for 'participative input,' but they rarely encourage real dissent with their own views."

The tendency to move toward tighter control during periods of uncertainty is a result of organizational tradition. As Basil and Cook (1974) note:

Both theory and practice in management thus bear the burden of decades of acquired tradition, learned during a time in which organizations identified with a narrow line of endeavor, when

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corporate missions were more definable and operational, and when the environment was fairly certain and controllable.

Clearly, lessons from the past are not always good guides for the future (Lant and Mezias, 1990).

An organization can improve its ability to adapt to change by assuming a more organic form. This requires the organization to resist the temptation to withdraw in time of change and to instead open itself to its environment. Many organizations fail to fully make the transition to an organic form. However, they do improve their odds of success by emphasizing leadership, participation, communication, and innovation.

Purpose of the Study

The purpose of this study is to evaluate the change-readiness of the USA MEDDAC at Fort Stewart, Georgia during late 1990 and early 1991 and to examine the degree to which it effects the MEDDAC's performance during a period of dramatic environmental change.

Propositions

Operation Desert Shield generated a period of dramatic change for the USA MEDDAC at Fort Stewart, Georgia. Some of the likely effects of this change can be projected based on the preceding review of the literature. The specific propositions to be examined in this study include:

1. The MEDDAC will need to take on a more organic, change-responsive form as it attempts to respond to dynamic environmental conditions.
2. As its environment changes, the MEDDAC will find it necessary to make structural and process changes.
3. As the environment becomes more complex, the MEDDAC commander will encounter greater difficulty in exercising direct leadership. He will rely increasingly on the other members of the command group to assist him in managing the organizational change.
4. Using Kotter's (1978) model, discussed in the next chapter, it is possible to project the moderate- and long-run implications of the MEDDAC's current actions.

III. A Model of Organizational Dynamics

Kotter (1978) developed his model of organizational dynamics on the premise that two interdependent sets of processes exist within all organizations. He labels these information generating processes and matter and/or energy converting processes. To survive, organizations must establish a favorable exchange relationship, one in which more matter/energy is imported than is exported, with an external environment. The key to generating matter/energy surpluses lies in information processes.

In the model, shown in figure 1, key organizational processes hold a central position, surrounded by the six structural elements of the organization: the external environment, employees and other tangible assets, formal organizational arrangements, the internal social system, the organization's technology, and the dominant coalition. Kotter (1978) maintains that the dynamics among and within these elements will determine the organization's success in the short, moderate, and long run.

Insert Figure 1 about here

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Kotter's model is designed as a tool with which to diagnose organizational effectiveness and make organizational improvement interventions. It also serves as an excellent vehicle for examining organizational responses to change.

Elements of the Model

Key organizational processes. As indicated above, all organizations have matter/energy processes and information processes. The process of combining professional, ancillary, and support services in treating a hospitalized patient is an example of a matter/energy process. According to Kotter's theory, the hospital must bring in more matter/energy (resources) than it expends in the patient care process. The hospital's ability to create such a favorable exchange with its environment is largely determined by the quality of the decisions made by the hospital executives in structuring the patient care process. The effectiveness of the decision making (information) process will determine the hospital's success or failure.

The formality, complexity, and effectiveness of organizational processes vary. To examine the key processes of an organization, it is necessary to trace

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the flow of matter/energy and information through the organization.

The external environment. To understand an organization's internal processes, it is necessary to understand its external environment. Kotter (1978) differentiates between an organization's task environment and its wider or general environment. An organization's task environment consists of those elements of the wider environment which are immediately relevant to the organization. Customers, suppliers, competitors, and markets are elements of an organization's task environment. The general environment consists of such things as the economy, the political system, public attitudes, and the state of technology.

Employees and other tangible assets. Kotter (1978) defines employees and other tangible assets as "the size (or number) and internal characteristics of an organization's employees, plant and offices, equipment and tools, land, inventories, and money." In this category, it is necessary to consider not only the skills and abilities of the organization's employees, but also their feelings about the organization and expectations for the future.

Formal organizational arrangements. Formal organizational arrangements are all of the formal systems designed to regulate the actions of employees. These formal arrangements include the structure and operating systems of the organization.

The social system. Kotter (1978) divides the internal social system into two parts: culture and social structure. Culture consists of organizationally relevant norms and values shared by most employees. Social structure consists of the relationships that exist among employees in terms of such variables as power, affiliation, and trust.

Technology. The major techniques used by an organization's employees while engaging in organizational processes are known collectively as the organization's technology. The organization's core technology, that which is associated with the organization's main product or service, is an important part of this element. Technology influences the shape of an organization's processes by making some things feasible and some not.

The dominant coalition. The dominant coalition is the core group of cooperating employees who oversee the organization as a whole and control its basic policy

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making. This group may be as large as twenty people or as small as zero. It is important to consider the personal characteristics, internal relationships, and objectives and strategies of this group. Kotter's premise is that those who control an organization invariably leave their fingerprints on it.

Using the Model

Kotter (1978) contends that three time frames are relevant in studying organizational dynamics: The short run (a few hours to six months), the moderate run (six months to six years), and the long run (six to sixty years). The seven elements of the model interact to create differing patterns of organizational dynamics in each of these time periods.

Short-run dynamics. Cause-and-effect relationships between the six structural elements and the organizational processes are the key short run system dynamics. The structural elements shape the organizational processes, while the organizational processes influence the shape of the structural elements. This seemingly straightforward pattern can be more complex than is initially obvious. As Kotter (1978) notes:

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The exact effect a structural element or a change in a structural element will have on an organization's key processes is a function not only of the prior states of the processes and that single element, but of the states of the other structural elements as well.

One must recognize that the relationship between each structural element and the key processes is influenced by the other structural elements as well. Similarly, changes in organizational processes must be considered not only in terms of their effect on one or two structural elements but in the context of the whole model.

Moderate-run dynamics. In the moderate run, much greater changes are possible than was the case in the short run. Moderate-run dynamics are determined by the degree of alignment which exists between the six structural elements. According to Kotter (1978):

When an organization's formal arrangements, employees and other assets, external environment, technology, internal social system, and dominant coalition have characteristics that "fit" together, that are "consistent" and "congruent," that are "coaligned," one tends also to find

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efficient matter/energy processes, effective information processes, and stability within a moderate time frame.

Changes generate the potential for nonalignments among the structural elements. When such nonalignments occur, the states of the nonaligned elements change over a period so that the relationships are once again aligned. Nonalignments are corrected through complex series of specific events (short run dynamics).

Nonalignments lead to inefficiencies and waste in matter/energy processes. Although nonalignments tend to correct themselves following the path of least resistance, certain factors may cause these inefficiencies to persist. For instance, an organization which feels no competitive pressure to change may protect and defend certain nonalignments. Likewise, an organization's dominant coalition might neglect structural nonalignments in the rush for short-term results.

Long-run dynamics. Kotter (1978) maintains that long-run dynamics are determined primarily by the organization's driving force and the level of adaptability built into its systems. The driving force of an organization is that structural element which has

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the greatest impact on the key processes. The other structural elements tend to follow the driving force in order to maintain alignments. Thus, the driving force tends to set the direction of the organization.

Adaptability is the key to organizational survival. The organization must adapt to internal and external changes in order to reduce nonalignments. Nonalignments which are not corrected quickly drain matter/energy from the system. Therefore, unless an organization has unlimited resources, it must act to correct nonalignments.

The states of the structural elements determine the organization's long-run success. As Kotter (1978) points out:

Social science and managerial research suggest that an organization's ability to adapt to changes over the long run is primarily a function of the states of its structural elements. Those states can range anywhere on a continuum from highly constraining of organizational processes and hard to align with other structural elements, to very unconstraining and easy to align.

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Without the application of time, effort, and resources, the structural elements tend to become more and more constraining and less and less alignable over time.

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IV. Method and Procedures

Unit of Analysis

The MEDDAC, including all clinical and administrative elements, will serve as the unit of analysis for this study. Personnel assigned to the MEDDAC but attached to other units (e.g., the 24th Division) and members of other units who are attached to the MEDDAC (e.g., nondeployable members of mobilizing Army Reserve units) will be considered members of the MEDDAC and therefore part of the study.

Study Design

The case study was selected as the format for this research. "It is the preferred method for examining contemporary events when relevant behaviors cannot be manipulated. The case study involves the use of data or information over which the researcher has little or no control" (Szilagyi and Wallace, 1983). It is most appropriate when seeking answers to "how" or "why" questions posed within a real-life context. (Yin, 1989).

A frequently cited weakness of the case-study design is the lack of control it affords (Poister, 1978). Control refers to the ability of a researcher to manipulate the conditions or variables of a study.

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Experimental designs, generally used to conduct pure research in a laboratory setting, allow the researcher a high degree of control. Conversely, non-experimental designs, such as the case study, are often used in conducting applied research in the field under conditions which offer the researcher little or no control.

The degree of control present in a research study effects the validity of that study. Research conducted according to an experimental design is likely to have a high degree of internal validity. That is, it can be expected to accurately reflect the state of the specific entity under study. Studies which use nonexperimental designs may be subject to criticism for a lack of internal validity. On the other hand, nonexperimental studies are often felt to have greater external validity--to be more easily generalized to a larger population--than do experimental studies. (Poister, 1978).

The reliability of a study is also influenced by the research method chosen. Reliability refers to the consistency or replicability of a study's findings. In quantitative studies, reliability is frequently represented by a variety of numeric checks, thereby

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presenting seemingly strong evidence of a study's reliability. In qualitative studies, such as case studies, reliability is dependent upon the documentation maintained by the researcher. It is necessary to clearly depict the means used to gather evidence supporting the study's findings in an effort to demonstrate that other researchers, given the same situation, would come to the same conclusions. The issue of reliability is often raised as a strength of quantitative methods and a weakness of qualitative studies. (Kirk and Miller, 1986).

Quantitative methods, though generally considered "hard," may be weaker as a research strategy than are qualitative means. A weakness of quantitative studies is their reliance on positivistic assumptions which hold that only one correct answer exists to any question (Kirk and Miller, 1986). Such a view is necessary in a strategy which proposes specific relationships and purports to confirm or deny them on the strength of many basic assumptions. In such circumstances, "confirmation is exactly the opposite of insight" (Kirk and Miller, 1986). Qualitative research, in contrast, inherently recognizes a world in which differing views exist. "A world in which reality

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exists only in our appreciation of it" (Brown, undated). By relaxing certain narrow definitions, qualitative research facilitates discovery of the unexpected. As Kirk and Miller (1986) note:

The general commitment of qualitative researchers to interacting with their objects on the latter's home ground strongly encourages the discovery that what the researcher takes for granted at his home does not apply in the new situation.

The case study, then, appears to be an appropriate strategy through which to answer the question now under consideration. Although considered the "weakest type of design" and "only as strong as its untested presumptions" (Poister, 1978), case study research is, in fact, remarkably hard (Yin, 1989).

Data Collection Methods

As indicated above, this research has been conducted according to the case-study design. It relies upon accepted modalities of case study data collection including participant-observation, document review and content analysis, and unstructured and structured interviews (Yin, 1989).

As a member of the MEDDAC staff, the researcher attended many meetings, participated in many

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discussions, and perhaps influenced some decisions. Participant-observation was therefore, a necessary source evidence. The role of participant-observer offered advantages in the form of access to people and events, and the ability to gain an insider's view of the MEDDAC. However, a difficulty inherent to this method is its potential to bias the results of the study. As Yin (1989) notes, "the danger is that the participant-observer may have to assume a position of advocacy, may become a supporter of the organization under study, and may devote too much effort to the participant role relative to the observer role." These are valid concerns.

Document review is another source of data collection which was used in this study. Documents that were reviewed include minutes of meetings, internal and external messages, and MEDDAC mobilization and contingency plans. The objective of the document review was to follow the flow of events and to identify the state of organizational structures and processes, and any changes which came about during the study period (i.e., changes in communication patterns, changes in roles and responsibilities, changes in performance, etc.).

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Interviews served as a primary method of data collection. Much of the interview data was generated from a series of structured interviews (see Appendices A, B, and C for interview questions). The researcher interviewed each member of the MEDDAC command group, each MEDDAC division and department chief, and, a random sample of other members of the MEDDAC stratified by status (officer, enlisted, and civilian) and by duty (clinical and administrative). The objective of the interviews was elicit opinions from members of the MEDDAC concerning the current state of organizational structures and processes, changes brought about by Desert Shield, and the MEDDAC's readiness for change.

Unstructured interviews were conducted with staff members throughout the study period. Notes and tapes made during these interviews were used in the study in much the same manner as other notes taken by the researcher in his participant-observer capacity.

Logic Linking the Data to the Propositions

1. Organizations adapt more readily to change when they assume an organic form (Skibbens, 1974; Hornstein, 1986; Pascarella, 1989; Lant and Mezias, 1990). The proposition that the MEDDAC would adopt a

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more organic form is supported to the degree that the data indicate increased communications openness, a decentralization of decision-making, more participation in management, and increased innovation.

2. Operation Desert Shield created drastic changes in the MEDDAC's organizational environment. The literature overwhelmingly indicates that in conditions of dramatic environmental change, organizations must change as well (Kotter, 1978; Lant and Mezias, 1990; Meyer, Brooks, and Goes, 1990). Kotter's (1978) model suggests the immediate changes should be of a cause-and-effect nature between organizational structures and processes. The proposition that the MEDDAC would initiate changes in response to the conditions brought about by Desert Shield is supported to the degree that the data reveal increased change occurring within the organization.

3. Times of environmental change call for leadership (Kanter, 1989; Motzer and Boissoneau, 1989). However, such conditions also make the exercise of leadership exceedingly difficult (Gilmore, 1989). During times of change, group leadership may be more effective than leadership by an individual (Peters and Tseng, 1984; Pascarella, 1989; Gilmore, 1990). The

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proposition that the MEDDAC Commander would incur difficulty exercising direct leadership and therefore rely more on other members of the command group is supported to the extent that the results of interviews with the command group indicate this is the case and the degree that such perceptions are supported by data gathered through other means.

4. It is speculative at best to attempt to predict the future. However, recognizing this inherent weakness, Kotter's model can be used to generate moderate- to long-run implications for the MEDDAC by extrapolating from current observations. Such projections are presented simply as "food for thought" and are not be cast as substantive or substantiated research findings.

The conclusions of this study (Chapter XI) are based upon an evaluation of the data against the criteria indicated above. The potential implications of the MEDDAC's actions are discussed in Chapter X, "Application of the Model."

Validity and Reliability of the Study

Validity and Reliability are complimentary terms. Validity indicates the degree to which a measure truly represents what it intends to represent. Reliability

refers to the consistency with which a measure produces the same results over different periods. (Poister, 1978).

Kirk and Miller (1986) maintain that any consideration of validity must begin by addressing the issue of theoretical validity. Yin (1989) notes that, in case study research, it is important to consider construct validity, internal validity, external validity, and reliability.

Theoretical Validity. All good research rests upon some theoretical basis. The degree to which the theory supports the research is described by theoretical validity.

The theory of organizational change, as presented here, holds that the characteristics of, and actions taken by, an organization greatly influence that organization's ability to adapt to change. Specifically, organic organizations are presented as more change-responsive than mechanistic organizations (Basil and Cook, 1974; Skibbens, 1974). As environmental change accelerates, organizations attempt to become more adaptive by shedding their mechanistic structures and opening themselves to their environments (Bartlett and Ghoshal, 1990; Lant and Mezias, 1990).

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They do this through leadership (Motzer and Boissoneau, 1989), communication (MacStravic, 1984), participation (Anderson, 1990), and innovation (Hornstein, 1986).

The dynamics of an organization responding to change vary over short, moderate, and long-run time periods. In the short run (the period covered by this study), these dynamics are of a cause-and-effect nature between the structural elements of the organization and its key processes. Based on short-run observations, it may be possible to project moderate- and long-run effects of a change. (Kotter, 1978).

The theoretical validity of this study can be judged against the typology of organizational change presented here. The study may be considered theoretically valid to the degree that the literature review, as summarized above, accurately reflects the theory of organizational change and to the extent this theory is operationalized in the study.

Construct validity. Construct validity requires that correct operational measures be established for the concept or concepts being studied (Yin, 1989). In this case the concept being studied is organizational responsiveness to change. This concept is operationalized in terms of organizational structures

and processes, and the characteristics of leadership, communication, participation, and innovation. The construct validity of the study can be judged by how well these constructs represent organizational responsiveness to change.

There are a number of measures which contribute to the construct validity of a study. These measures include: Use of multiple sources of evidence, use of chains of evidence, and review of drafts of parts of the study by key informants (Yin, 1989). All of these measures were utilized in the conduct of this study.

Internal validity. The internal validity of this study is determined by how well the findings reflect the true state of affairs within the MEDDAC during the study period. There are numerous threats to the internal validity of any study. The two primary validity threats which are relevant to this study are history, and maturation. History, in this case, implies that the dynamics occurring within the organization during the study period represent something other than the organization's attempt to respond to change. Maturation, which refers to changes

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occurring naturally over time and not as a result of any particular phenomena, is of lesser concern in this case.

To protect the internal validity of this study, several techniques were used. Pattern-matching, in which the researcher will examine the various sources of evidence for patterns that tend to support or refute the propositions of the study, is one such technique. Using another technique, known as time-series analysis, the researcher looked for theoretically based trends (i.e., improving communication evidenced in committee minutes and interview results). Finally, the entire study represents an attempt to build an explanation for why the MEDDAC performed as it did during the study period. (Yin, 1989).

External validity. External validity indicates the generalizability of the findings of a study to a larger environment (e.g., to all Army MEDDACS). The primary threats to the validity of this study are reactive effects and situational effects. Reactive effects refer to the tendency of people to act differently than they otherwise might when they know they are under study. Certainly, it is possible that the individuals questioned in this study over or

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understated their true feelings simply because they were asked. Situational effects refer simply to the fact that no two organizations are exactly alike. The Army MEDDAC at Fort Stewart is clearly different in many ways from any other MEDDAC. However, it is also like all MEDDACS in many ways. The similarity of this MEDDAC to others promotes the external validity of this study.

The external validity of this study should not be overly degraded simply because the study only represents a sample of one. The goal of qualitative research is analytical not statistical generalization (Yin, 1989). Therefore, the intent is to generalize from the results of this study--that the MEDDAC's responsiveness to change did or did not enhance its ability to perform its mission--to the theory that change-responsive organizations out perform nonresponsive organizations in periods of rapid environmental change.

Reliability. In qualitative research, reliability depends essentially on explicitly described observational procedures (Kirk and Miller, 1986). Reliability can be protected by using a well-developed case study protocol and by maintaining a case-study

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data base. The goal is to minimize errors and biases in the study. (Yin, 1989).

This research was conducted according to a detailed research plan (proposal). The use of a research plan, approved by members of the faculty which commissioned the study, enhances the reliability of this research effort. A central element of the plan called for the creation of a case-study data base consisting of: A daily journal; a file of interview summaries, notes, and tapes; a file of notes, messages, and MEDDAC correspondence and policies; and a file of miscellaneous field notes. Many of the reported observations were made only after repeated review and analysis of material contained in the case-study data base.

Validity and Reliability of the Survey Instruments

The objectives of the three survey instruments are: To get a general feel for the organization (its internal social system, key processes, formal arrangements, and employees); to determine what, if any, structural or process changes have occurred as a result of Operation Desert Shield, and; to identify characteristics of the MEDDAC which promote or inhibit organizational change and their impact on the MEDDAC.

The questions were developed to support these objectives. Specific questions from each interview format are matched with the objectives they are designed to meet in table 1.

The interview questions were drawn from the literature review, which establishes the theoretical basis of this study. The interview questions then, represent an attempt to operationalize theory in the context of the MEDDAC.

Theoretical validity. The theoretical validity of the survey instruments is demonstrated by following the logic of table 1. Each question relates to one or more of the objectives which are theoretically based indicators of organizational change-responsiveness. The interview formats are felt to be theoretically valid, then, because they are based upon the body of theory on which the study rests.

Construct validity. Two individuals reviewed the interview questions. They discussed their perceptions of the questions with the researcher who noted their initial impressions. The researcher then explained the intended relationships of questions to constructs and provided a copy of table 1 which shows these intended relationships. The reviewers again discussed their

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perceptions of the questions and their relation to the constructs. Some of the questions were modified or rewritten based on reviewer input. It is felt that the review process strengthened the construct validity of the interview formats.

Insert Table 1 about here

Internal validity. A key determinant of the internal validity of an instrument is its ability to help answer the research question (Szilagyi and Wallace, 1983). In this case, it is necessary to gauge both the change-readiness of the MEDDAC and the impact this has had on the MEDDAC's ability to accomplish its mission. The interview questions were developed with this in mind. The questions in table 1 which correspond to the adaptive characteristics are designed to generate information concerning the MEDDAC's change-readiness. The questions corresponding to general feelings and organizational changes are designed to assess the impact of the MEDDAC's change-readiness on its performance.

External validity. As indicated above, qualitative research seeks analytical generalization.

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The goal, in this case, is to generalize from the results of the study to the theory of organizational change. The survey instrument should, therefore, provide some ability to take information from the MEDDAC and put it in the larger context of theory. The questions, as demonstrated in table 1, are designed to facilitate this goal.

Reliability. The reliability of an instrument can be influenced by the interpretations of those using the instrument (Poister, 1978). The interviewees should interpret the questions in the same manner as does the interviewer. The review of the interview questions by two individuals should help assure reliable answers. Other indications of reliability might become obvious when the interviews are conducted. For instance, the interviews should produce information which is consistent with information generated from other sources. If this does not occur, the reliability of the interview formats could be questioned.

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SECTION 2: Supporting Operation Desert Shield

The labels "Pre-deployment Phase," "Reserve Mobilization Phase," and "Post-deployment Support Phase" were created by the researcher. They serve simply to subdivide the total operation for the researcher's (and hopefully the reader's) convenience. These phrases have no meaning beyond their use in this study.

V. Pre-deployment Phase

The pre-deployment phase of Operation Desert Shield began at Fort Stewart at the time of the Division alert, August 6, 1990. This phase continued until the first elements of the 24th Division began deploying from Fort Stewart to Saudi Arabia on August 24, 1990. Predeployment activities continued beyond this date as the post supported the deployment of the remainder of the 24th Division; the 197th Mechanized Infantry Brigade, from Fort Benning, Georgia (attached to the 24th Division in place of its National Guard round-out brigade); miscellaneous Army Reserve and National Guard units mobilizing through Fort Stewart;

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and the 48th Mechanized Infantry Brigade of the Georgia Army National Guard, the 24th Division's identified "round-out" brigade.

MEDDAC Notification

The MEDDAC was among the last of the units on Fort Stewart to become aware of the division alert. Notification came through unofficial channels when the Division Surgeon called the MEDDAC's Deputy Commander for Clinical Services (and acting hospital commander) late on the night of August sixth. The Deputy Commander for Clinical Services (DCCS) notified the MEDDAC Commander who was away on temporary duty. The next morning, while the Commander was en route back to Fort Stewart, the DCCS attended an installation briefing where he got the initial picture of what was happening.

The MEDDAC Commander arrived on the afternoon of August seventh and was briefed on the situation. He immediately cancelled all leaves and began to scrutinize the Professional Officer Filler System (PROFIS) roster. Meetings were held with key staff to assess the situation and plan to support the

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deployment. An Emergency Operations Center (EOC) was established in the MEDDAC and staffed around the clock by officers and noncommissioned officers.

Soldier Readiness Processing

The MEDDAC's first major task in supporting the Division's deployment preparations was to support the Soldier Readiness Processing (SRP) sites. The Division Surgeon typically coordinates the medical portion of the SRP and the Division Medical Supply Office (DMSO) provides requisite medical supplies. This mode of operation is geared to mobilizing a brigade at a time. The plan was exercised regularly during deployments to the National Training Center (NTC) and had always worked well. However, the Division Surgeon and DMSO alone were not capable of supporting a total division deployment. Consequently, problems arose almost immediately and the MEDDAC picked up both the SRP and medical supply missions within days of the alert.

SRP medical support. Clinical Support Division maintained a duty roster of physicians tasked to support the SRP. To the extent possible, nondeploying physicians, including the MEDDAC Commander, were assigned this task.

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Frequently during the SRP process, questions arose as to a soldier's deployability. If a soldier required specialty evaluation beyond the capability of the physician on-site, the soldier was taken by a MEDDAC patient-transport vehicle to the appropriate specialty clinic in the MEDDAC for immediate evaluation. When necessary, the MEDDAC Commander would evaluate the soldier and make the final deployability recommendation to the unit commander. This policy led eventually to the MEDDAC Commander or his designee, usually the DCCS, making the final recommendation in every case. The Commander spent approximately 70 percent of his time during the pre-deployment phase conducting deployability evaluations for individual soldiers (C. H. Hood, personal communication, February 26, 1991). This continued to require significant amounts of his time throughout the other phases of the Operation.

The large number of soldiers determined to be nondeployable indicated a failure of the Military Medical Review Board (MMRB) to appropriately identify and remove or reclassify soldiers with medical problems. The MEDDAC Commander noted that the MMRB needs to be reinvigorated. Specifically, he felt it should meet more frequently and act more aggressively

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in identifying soldiers with performance limiting conditions (C. H. Hood, personal communication, August 18, 1990).

SRP supply support. The initial supply problems resulted from a lack of planning, communication, and accountability. According to a medical logistics officer from the MEDDAC staff, "We had the kind of problems you would expect in a situation which had never been practiced before" (A. Wilkes, personal communication, February 25, 1990). The DMSO was initially unsure which immunizations were required and consequently ordered some which were unnecessary (e.g., \$53,000 of polio vaccine). Before the Division SRP was announced, each battalion began drawing vaccines, planning to give its own immunizations. Consequently, the DMSO was inundated with requisitions from battalions, brigades, and the division, which it filled on a first-come-first-served basis. Simultaneously, the medical platoons and medical companies were inundating the DMSO with requisitions to replenish their medical sets, kits, and outfits. The DMSO, struggling to prepare itself for movement and

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concurrently manage a dramatically increased workload, was unable to fill all of the requisitions and lost accountability on many of those which it did fill.

The Materiel Branch of the MEDDAC's Logistics Division picked up the DMSO mission on August 11th. They quickly established controls for the issue of vaccines. Since the MEDDAC was now running both the operation and supply of the medical SRP, this was not difficult. Ambulatory Care Nursing, which had the mission of staffing and orchestrating the immunization teams, identified specific individuals to whom vaccines would be issued. Materiel Branch issued only to these designated individuals.

The Troop Medical Clinic Mission

In addition to orchestrating the medical portion of the SRP, Ambulatory Care Nursing Service, in conjunction with Clinical Support Division, also took over operation of the three troop medical clinics (TMCs). The three clinics were consolidated to one shortly after the alert. These additional missions were not overly burdensome to Ambulatory Care Nursing Service which was able to get ample support from the Department of Nursing. In fact, nursing personnel became more available for diversion from their

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inpatient duties as the inpatient census fell by almost fifty-percent within less than a week. (J. A. Nelson, personal communication, Septemeber 10, 1990).

The PROFIS System

Another major occupation during this phase was getting the PROFIS physicians matched up with their units and processed through the SRP. These activities were planned and coordinated by the Deputy Commander for Clinical Services (DCCS) and the Chief of Clinical Support Division (CSD). Although the MEDDAC's PROFIS system had been in place for some time, problems arose because physicians were not identified with specific units. Initial PROFIS assignments did not reflect the most efficient utilization of resources (e.g., a lieutenant colonel orthopedic surgeon assigned as a brigade surgeon/medical company commander). However, the PROFIS slots had to be filled with MEDDAC staff physicians. Consequently, ranks and specialties did not always match those recommended for the position.

Coincidentally, Health Services Command (HSC) conducted a surprise inspection of the MEDDAC's PROFIS plan on August 2, 1991. The response rate was 94 percent and only minor deficiencies were noted in such areas as immunizations and panorexes. The inspector

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commented that it was the best performance she had seen (C. H. Hood, personal communication, August 2, 1990).

Peacetime inspection standards for PROFIS are obviously inconsistent with actual wartime requirements. This fact became readily apparent upon the activation of the MEDDAC's PRCFIS plan. Many problems surfaced when the plan, rated outstanding less than a week previously, was put into effect. Some of these problems could have been easily identified by simply considering the minimal training afforded PROFIS personnel. They are required to qualify with a weapon annually. This is the only PROFIS field training requirement. There is no requirement that PROFIS personnel go to the field with their unit, nor that they visit the unit at all. Army MEDDACS have no authorized field equipment (e.g., tentage; field medical equipment) with which to conduct field training. Even the Medical Care Composite Unit (MCCU) reimbursement system discourages field training for physicians by penalizing the commander who decides to send physicians to the field rather than keeping them in the clinic. The Fort Stewart MEDDAC Commander repeatedly expressed concern at being required to potentially send his physicians in harm's way without

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adequate training (C. H. Hood, personal communication, August 17, 1990).

Availability of care

At a Division deployment planning meeting on the night of August 8th, the Division Commander told the MEDDAC Commander to attach the PROFIS physicians to their PROFIS units immediately. The MEDDAC Commander responded that to do so would require him to cease dependent care. The consequences of such an action apparently were not immediately evident to the Division Commander.

The following morning, August 9th, the MEDDAC Commander made rounds to all the clinics informing the PROFIS physicians they should get ready to deploy and advising patients to use CHAMPUS as no more dependent care would be available. Later that morning the Commander announced the termination of dependent care to the key staff assembled for morning report. Some objections were raised but the Commander explained his orders from the Commanding General and indicated that dependent care could not continue. He further advised the staff to prepare to transfer out dependent and retiree inpatients who could not be discharged within three days. The Commander concluded the meeting by

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clearly depicting the MEDDAC's new mission saying, "We have only one job, soldier support, everything else is secondary" (C. H. Hood, personal communication, August 9, 1990).

Following the staff meeting, the Commander explained in a videotaped message the MEDDAC's actions and the reasons for them. The tape was intended for broadcast on the installation television network, however, it was never shown. At noon that day, the Commanding General appeared at the MEDDAC and ordered the MEDDAC Commander not to cut dependent care. He initially asked the MEDDAC Commander to reduce the quality of care a bit in order to maintain the quantity. When the MEDDAC Commander explained that such was not possible, the Commanding General indicated he would return the PROFIS physicians so that dependent care could be maintained.

In many cases, the units were reluctant to release their PROFIS physicians, but they gradually did so and dependent care continued. After having initially notified Health Services Command (HSC) that the PROFIS physicians had been released and backfills were needed as soon as possible, the MEDDAC now informed HSC that the physicians were back, and the need for backfill was

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not so urgent. MEDDAC operations returned to near-normal and physicians were encouraged to go to their PROFIS units after normal duty hours. Needless to say, the physicians were uncomfortable with this arrangement and felt the Commanding General had sold them out.

Clinical Support Division had the difficult job of trying to maintain some kind of a clinic schedule during this tumultuous period. The MEDDAC Commander initially directed that all clinic appointments for non-active duty personnel be cancelled. He later countermanded this order and directed that appointments be made one week at a time. Physicians were to be in the clinics during duty hours except when required to go through the SRP, support the SRP, or attend chemical agent training with their units. Scheduling outpatient clinic appointments under these circumstances was extremely difficult. In some cases, clinics would operate at near normal capacity one day and at near zero the next.

The PROFIS Physicians

The frustration felt by the physicians was evident in a discussion this researcher had with one of them approximately one week after the alert. The physician

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said he supported the President's decision and, although "not very happy about it," was determined to do his part. His primary concern was his lack of training in self-defense against chemical agents and inability to treat chemical agent casualties. He indicated that, since becoming an officer, he has had no training in this area. Another concern expressed by this officer was his lack of familiarity with his medical platoon (of an infantry battalion in this case) and with medical platoon operations in general. He said that prior to the alert he did not know which unit he was "PROFISED" to and had not spent time with any unit. In the week since the alert, he had spent less than an hour with his unit. He explained that he had been on-call on Friday, was off and slept on Saturday, and was again on-call on Sunday. During the week he had maintained his regular 0630-1830 work schedule, leaving little time to get with his unit. He was very angry that the Commanding General had required the physicians to continue seeing patients. In one statement, he summed-up these feelings saying, "the Commanding General is telling us, 'you're not important enough to receive training'" (S. Meese, personal communication, August 14, 1990).

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The Commanding General's direct order that the MEDDAC not reduce the quantity of care available, coupled with the delay in getting backfill physicians, gave the MEDDAC Commander little flexibility. He released PROFIS physicians to their units when backfill physicians arrived on a one-for-one basis. Since some of the backfill physicians arrived only days prior to the deployment, many of the PROFIS physicians had very little time with their units. It is fortunate that they had time for training upon their arrival in Saudi Arabia and were not thrown immediately into a combat situation.

Communication Problems

The MEDDAC and HSC did not communicate well on the subject of PROFIS physician deployments. Upon receiving the order to attach PROFIS physicians to their units, the MEDDAC sent a message to HSC requesting immediate physician backfill. When the Commanding General released the physicians back to the MEDDAC, the MEDDAC sent another message to HSC indicating this and informing HSC that the need for backfill was not now so immediate. The HSC staff seemed to understand that until the PROFIS physicians actually departed, there was no need for backfill. It

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is possible the MEDDAC fostered such a misunderstanding with seemingly contradictory messages within less than a day of one another. The MEDDAC tried repeatedly to explain to HSC that it needed backfill physicians as soon as possible so that the PROFIS physicians could go to their units and receive the training they so desperately needed. Eventually, the MEDDAC Commander discussed the problem directly with the HSC Commander who admitted that the HSC staff had been slow in catching on to the situation (C. H. Hood, personal communication, August 21, 1990).

The HSC staff was not alone in misunderstanding the need to have backfill physicians on site prior to the departure of the PROFIS physicians. Upon arriving and noting that the division had not yet deployed, one of the backfill physicians called his home station complaining that he did not need to be here because none of the assigned personnel had left.

Communications problems continued between the MEDDAC and HSC regarding backfill physicians. Physicians' names, specialties, and arrival dates were frequently uncertain. In some cases, physician backfill assignments seemed nonsensical. HSC sent many internists when the MEDDAC needed general medical

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officers to run the outpatient clinics. The internists were "usable," but their skills were certainly not put to optimal use. In one case, a neonatologist who had not practiced general pediatrics for ten years was sent to fill a pediatrician slot. The MEDDAC was able to swap this physician with the regional medical center for a general pediatrician. In another instance, a backfill physician from Fort Dix was mistakenly sent to Fort Stewart rather than Fort Bragg as had been intended. When the mistake was discovered, the physician was sent on his way and the MEDDAC requested a "back-back fill."

Communication between the MEDDAC and the regional medical center, Dwight David Eisenhower Army Medical Center (DDEAMC), did not change significantly with the onset of Desert Shield. The first contact between the MEDDAC Commander and the DDEAMC Commander occurred on August 12th. During this call the MEDDAC Commander simply updated the DDEAMC Commander as to what was happening at Fort Stewart.

Supporting the Backfill Physicians

Inprocessing, billeting, transportation, and credentialing were issues which had to be handled upon the arrival of backfill physicians. When the first

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four physicians arrived, the guest house and local motels were all booked-up. These physicians spent their first night at Fort Stewart in the MEDDAC. Subsequently, a number of rooms were held at the Bachelor Officers' Quarters (BOQ) for incoming physicians. Many of the backfill physicians brought their personal automobiles with them. Those without a personal vehicle were transported to and from the MEDDAC in a duty vehicle. An abbreviated inprocessing form was prepared to expedite their inprocessing. Credentialing was also greatly expedited. The sending MEDDAC simply provided a letter to the receiving MEDDAC explaining the physician's privileges. The receiving MEDDAC Commander then extended the physician courtesy privileges for 180 days.

Shortly after their arrival, the backfill physicians attended a miniature transition-to-practice seminar hosted by the DCCS and Chief of CSD. During the two-hour session, subjects such as quality assurance, medical records accountability, and clinic schedules were discussed.

New Missions

As the MEDDAC struggled to support the deployment while maintaining undiminished access to care for all

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beneficiaries, it found new missions falling into its lap. Among the first of these new missions was support of the Family Assistance Center.

Family Assistance Center. The pending deployment and potential for war created a tremendous amount of anxiety among the families of 24th Division soldiers. The Family Assistance Center was designed to help relieve anxiety by providing information, referrals, and personal assistance to families of deploying soldiers. Available services included regularly updated deployment information, status reports on the situation in the Middle East, legal assistance, financial counseling, mental health and crisis intervention, and a variety of other social service activities.

The MEDDAC's Community Mental Health Activity (CMH), supplemented by the professional staff from the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP), provided 24 hour coverage at the Family Assistance Center. The CMH station at the Family Assistance Center served as a non-hospital source of crisis intervention, counseling, information and referral for families. This outreach effort met a vital need by being readily available to families who

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might not have sought help in a hospital or medical facility. The CMH staff preempted many potentially problematic situations through prompt intervention at the Family Assistance Center.

During the predeployment phase, the efforts of the Community Mental Health Activity and those of the Division Mental Health Section complemented one another. While the CMH Activity provided support and assistance to family members, the Division Mental Health Section did much the same for the deploying soldiers. Community Mental Health efforts for family members centered on practical advice, referrals, counseling, and crisis intervention. Meanwhile, the Division Mental Health Section provided classes on battle fatigue, sleep deprivation, and stress management for the soldiers. Although the results of such preventive measures are difficult to quantify, it is safe to assume that the soldiers and families of the 24th Division benefited from these proactive mental health services.

The MEDDAC also provided a medical information station at the Family Assistance Center. This station was staffed by the MEDDAC's Patient Representative who provided information on the availability of

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appointments in the various clinics. The patient representative also helped family members with questions regarding use of the CHAMPUS program.

TMC support. The TMC support mission, referred to previously, was picked-up jointly by the Ambulatory Care Nursing Service and Clinical Support Division. As with the SRP, Ambulatory Care Nursing provided the nursing staff for the consolidated TMC and Clinical Support Division coordinated physician staffing. Once again, with the reduced MEDDAC inpatient workload, availability of nursing personnel was not a constraint. However, MEDDAC physicians were stretched to the limit and staffing the TMC was one more burden to bear.

Convoy support. Some less-expected missions came up as the division began moving its equipment. Much of the equipment was moved by convoy on the interstate highway between Fort Stewart and the Port of Savannah. Frequently, the MEDDAC provided the medical support for these convoys. Medical support to convoys was coordinated between Plans, Training, Mobilization, and Security (PTMS) and Clinical Support Division. Plans, Training, Mobilization, and Security Division got convoy information from the Division Transportation Officer and passed this on to CSD. Clinical Support

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Division then detailed an ambulance crew to follow the convoy to the port.

Port support. Medical support was also necessary to support ship loading operations at the port. The ship loading operation continued over a period of many weeks. The MEDDAC stationed a physician and an ambulance, with crew, at the port throughout this period.

Each ship took with it a crew of one hundred soldiers to move the equipment off the ship upon arrival in Saudi Arabia. Since the ships had no organic medical support, the Division Surgeon placed one physician's assistant and two medics with appropriate medical supplies on each ship. The MEDDAC Commander was instrumental in designing these medical support packages.

Airfield support. The actual deployment of troops occurred from Hunter Army Airfield in Savannah. Units were moved to Hunter Army Airfield approximately eighteen hours prior to their scheduled departure. Once again, the MEDDAC provided on-site medical support throughout the staging and airloading operation. The

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MEDDAC also beefed-up its Tuttle Army Health Clinic staff (located on Hunter Army Airfield) in case of an aircraft emergency or mass-casualty situation.

MEDDAC Innovations

Throughout the pre-deployment period, the MEDDAC continued to encounter unusual and often unexpected situations. One such situation occurred when the MEDDAC learned of the deployment of the division's military police (MPs).

Obtaining Emergency Blood Products. When an emergency need for blood products arose, the MEDDAC would contact the MPs who would send a car with class 1 authority (lights and siren) to Memorial Hospital in Savannah to pick-up the blood products. With the deployment of the MPs, a new procedure was required. Under the new procedure, worked-out by CSD, ambulance personnel on Hunter Army Airfield were notified of the blood emergency. They would go to Memorial Hospital, pick-up the blood products, and take them to a prearranged meeting place between Fort Stewart and Savannah. There the MEDDAC's EOC driver would meet the ambulance, take the blood products, and bring them to the MEDDAC. This system worked well when it was used.

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Use of ADAPCP staff. The dramatic increase in the demand for mental health and social support services was also unexpected, although clearly not unusual in light of the situation. The reorientation of the ADAPCP staff to support this new demand was a prudent reallocation of resources to meet an acute need.

Alcohol and drug counselors assisted at the Family Support Center, offered parenting and stress management classes, provided crisis intervention, and helped establish chains of concern.

Situation in the MEDDAC

Activity in the MEDDAC during the predeployment phase was anything but normal. Leaves were cancelled and the key staff worked seven days a week. Physicians hurried about trying to finish up details to prepare themselves for departure. The administrative staff was struggling for information upon which to make decisions. Questions like how many physicians will deploy, how many will be backfilled, when will they arrive, will we continue seeing patients, should we prepare to support casualties, will the Army Reserve be called up and what will that mean, were all difficult to answer. The nursing staff evaluated bed-space and considered expansion capabilities, while supporting the

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MEDDAC's new missions. Meetings were held and contingency plans were developed.

Plans, Training, Mobilization, and Security Division. Each division and department within the MEDDAC did what it could to support both the deployment and the continuation of patient care. The Chief of Plans, Training, Mobilization, and Security Division (PTMS) acted as the liaison between the MEDDAC and the Division, attending the twice-daily Division planning meetings: "He coordinated the Division's requirements for support from the MEDDAC. These included both requests for medical support and for training assistance. Plans, Training, Mobilization, and Security Division was intimately involved in planning the SRP and in arranging medical support for convoys and at the port of embarkation. The PTMS staff also coordinated and often directly provided training to deploying physicians and other medical personnel at the request of the Division Surgeon. The Chief of PTMS and other members of the MEDDAC staff provided training on battlefield medical doctrine, casualty evacuation procedures, preventive medicine, and chemical casualty management. The Chief of PTMS arranged to have a team of experts from the Chemical Research and Development

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Command visit Fort Stewart to provide a series of classes on treatment of chemical agent casualties. Feedback from participating physicians indicated these classes were among the most valuable training they received prior to the deployment.

Clinical Support Division. The Chief of Clinical Support Division (CSD) was one of the individuals in the MEDDAC with whom the Chief of PTMS most frequently coordinated. The Chief of CSD monitored the physicians' schedules and, with the Deputy Commander's authority, tasked physicians by name to support the various activities ongoing during the predeployment phase. Another major preoccupation for CSD was trying to know from one day to the next what clinics would be open, at what level, and what services would be offered. The Chief of CSD produced a daily status sheet indicating the availability of care in the various clinics. This was given to the patient representative at the Family Support Center who could pass the information along to family members. To minimize the time physicians were required to be away from the clinics when their units were being "SRPed," CSD provided them transportation to and from the SRP site.

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Personnel Division. Personnel Division was among the busiest elements of the MEDDAC during the initial phase of Operation Desert Shield. They were heavily involved with the PROFIS activation and found that several PROFIS officers, thought to be fully deployable, were, for one reason or another, unable to deploy. In such cases, the Chief of Personnel Division would notify the DCCS who would identify a substitute. Personnel Division was in close contact with both the 24th Division G-1 (personnel section) and HSC. They gave the G-1 the final PROFIS list allowing G-1 to prepare orders attaching the PROFIS physicians to the division. Personnel Division regularly communicated the MEDDAC's physician status and need for backfills to HSC.

Personnel Division was a key player in preparing PROFIS personnel for deployment. They reviewed and updated the PROFIS SRP packets. This allowed the MEDDAC's PROFIS personnel to proceed through the Division SRP quickly, usually requiring only immunizations to complete their SRP requirements. While reviewing SRP packets with PROFIS personnel, Personnel Division prepared powers of attorney for those who needed them.

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Personnel Division prepared a list of names and addresses of the spouses of deploying soldiers. They put together a detailed information packet for the spouses which provided practical advice and answers to common questions. This information packet was used as a model by the regional medical center.

In addition to the activities involved with supporting the deployment, Personnel Division continued its day-to-day mission in support of the MEDDAC. This required frequent communication and interaction with various elements of the 24th Division staff. Personnel Division had a good relationship with these offices and the MEDDAC consequently enjoyed excellent support from the post. However, with the onset of Desert Shield, many key personnel in these various agencies were pulled out in preparation for deployment. Personnel Division found that, in almost every office, its regular points of contact were no longer available. Most of these agencies were now incapable of providing the level of support they had maintained prior to the onset of Desert Shield. Support from the post became inconsistent and in some cases nonexistent throughout the pre-deployment phase. Personnel Division weathered this period of diminished support, but not without

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criticism from MEDDAC personnel who were unaware of the constraints Personnel Division was facing.

Logistics Division. Logistics Division, perhaps more than any other activity in the MEDDAC, played a vital role in supporting the Division in its deployment preparations. As mentioned previously, Materiel Branch assumed the DMSO mission at a very early stage. Prior to this point, Materiel Branch supported the DMSO, filling requisitions which were passed to it.

A review of these requisitions revealed some of the problems the DMSO experienced. Initially, DMSO requested eight different vaccines, only to find that only four of these were required. It also encountered problems determining appropriate quantities of each vaccine to order. The first requisitions were for enough vaccines to immunize a brigade--which is the size force initially thought to be deploying. The DMSO later made requisitions for sufficient vaccines to immunize the entire Division. Dosages and vaccine units of issue were problematic. In the case of one vaccine, the DMSO thought each vile contained sufficient volume for four immunizations when in

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reality it contained enough for only two.

Consequently, four orders for this vaccine were placed in the first days of the operation.

The confusion subsided when Materiel Branch took over the DMSO role. This is not to say that Materiel Branch was able to easily manage the division medical supply mission while continuing its routine functions in support of the MEDDAC. Rather, Materiel Branch, by working extended hours and focusing strictly on meeting medical supply needs (and not burdened by preparations for deployment as was the DMSO), established an orderly system for filling requisitions, anticipating needs, and identifying oversights.

Materiel Branch also helped units determine which supplies were necessary to replenish their medical sets, kits, and outfits; medical aid bags; and combat lifesaver bags. An interesting discovery was that most of the battalions, including many with women assigned, did not have vaginal creams, tampons, douches, birth control pills, and other gynecological supplies.

The Chief of Logistics Division noted several factors which contributed to his division's success in supporting the deployment. First among these was their ability to anticipate potential needs and verify them

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with experts from other elements within the MEDDAC. When the 24th Division was alerted on August 7th, the Chief of Logistics Division met with the Chief of Preventive Medicine Service and other members of the MEDDAC staff to identify immunizations likely to be required. Logistics Division made its initial requests for vaccines, excluding those made for the DMSO, based upon the outcome of this brainstorming session.

The experience of the Logistics Division staff was another key to their success. From personal experience in divisional units, the Chief of Logistics Division and the Chief of Materiel Branch knew what their counterparts in the 24th Division faced in preparing for deployment. They understood the need to fill requisitions, often without question. They also realized that many of their customers, particularly among the deploying nondivisional units, did not understand medical supply and required assistance. Finally, because they recognized the tremendous pressures faced by the DMSO and Division Surgeon, Logistics Division readily accepted the DMSO mission. (D. O'Hare, personal communication, August 13, 1990).

Resource Management Division. As always, the role of the Chief of Resource Management Division (RMD) was

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to ensure the MEDDAC had the resources necessary to support current and future operations. Prior to receiving any guidance from HSC, the Chief of RMD told the MEDDAC staff to do what it took to support Operation Desert Shield--as the Commander had directed--but to maintain a record of costs. This, as it turned out, was exactly the guidance HSC ultimately provided. Resource Management Division established a new Account Processing Code (APC) to which all Desert Shield related expenses were applied. This enabled the MEDDAC to clearly identify those costs directly related to Desert Shield.

Information Management Division. Information Management Division (IMD) worked with the installation Public Affairs Office to control the release of information. The big question initially was: Will the MEDDAC stay open? Word had spread that the MEDDAC had cancelled appointments for non-active duty personnel creating a great deal of anxiety among the local population. After determining that the MEDDAC would indeed remain open and would continue seeing all categories of patients, IMD worked to get this information out to the public. The MEDDAC Commander conveyed this message in a tape for the installation

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television station and in a number of articles he wrote for the post newspaper. Unfortunately, some families remained unconvinced and departed the area rather than remain and risk loosing access to health care.

Information Management Division experienced a dramatic increase in its printing workload during the predeployment phase. Hundreds of copies of various training materials were made as PTMS and other MEDDAC elements provided training for deploying personnel from the MEDDAC and the Division. Information Management Division also produced thousands of pages of material for the information packets prepared for spouses and for backfill physicians.

Patient Administration Division. Patient Administration Division (PAD) was relatively unaffected by Operation Desert Shield during the predeployment phase. The one area in PAD which did receive increased attention was the Coordinated Care Branch. The MEDDAC Commander directed that the Coordinated Care Branch pursue CHAMPUS direct care provider partnerships in all areas. The renewed emphasis generated support for and acceptance of the coordinated care program. However, the Chief of Coordinated Care Branch was already pursuing partnerships across the spectrum of

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specialties, so the renewed charge did not really change his strategy.

An acute minor illness clinic, operated under the CHAMPUS Partnership Program, opened shortly after the onset of Operation Desert Shield. The Coordinated Care Branch of Patient Administration Division finished the negotiations for this clinic in July. The acute minor illness clinic was a "brainchild" of the MEDDAC Commander and had been in the works for quite awhile. It was fortuitous that the negotiations came to conclusion at this time. Formally designated the Ambulatory CHAMPUS Extended Service (or ACES) clinic, it significantly increased the MEDDAC's capacity to provide ambulatory care.

Optometry Section. The Optometry Section is one area that was truly inundated during the predeployment phase. The MEDDAC's three optometrists wrote over 7,000 prescriptions in a three week period. Over 8,000 pairs of spectacles (regular and tinted) and over 2,000 eye-lens inserts were issued to 24th Division soldiers. Unfortunately, there was little in the way of innovation which would relieve this burden. The optometrists simply extended their hours, working 18 hour days, to meet the surge in demand.

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The Chief of the Optometry Section identified a number of issues which he and his staff noted during this period. First, he felt the tremendous workload indicated that, although the Division had claimed to be fully deployment-ready, it had not taken optometric readiness seriously. Secondly, the optometrist noted that while the abbreviated medical record (HSC Form 621-R (Test)) was indeed helpful, it was not received until the Division SRP was near completion. Finally, he expressed frustration over the slow response by the optical lab in approving the issue of sunglasses. The optical lab did not approve the issue of sunglasses until one week prior to the deployment. The sunglasses had to be mailed to Saudi Arabia after the deployment. (J. H. Demler, personal communication, 21 October 1990).

Department of Nursing. As the MEDDAC focused increasingly on supporting the deployment, its census fell and with it the nursing workload. The Chief of the Department of Nursing consolidated two wards and reallocated many of her staff from inpatient care to support the MEDDAC's new missions. Nursing personnel staffed the Division SRPs around the clock. MEDDAC nursing personnel replaced 24th Division personnel

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staffing the TMCs. The MEDDAC's nursing staff even pitched-in to help staff the Family Assistance Center.

The Chief of the Department of Nursing indicated that much of her time during the early days of the Operation was spent controlling rumors. She felt that after the panic which resulted from the very short-term cancellation of dependent care, it was important to ensure that the MEDDAC staff had accurate information. She saw the predeployment period as a time for her staff to rest and prepare for the dramatic workload a war might create. As the census fell, her staff expressed growing discontent at being denied leave during a period of reduced inpatient activity. When the leave restriction was lifted, she encouraged her staff to take maximum advantage of this opportunity to use their leave. She felt the break they were getting now would pay off when and if the MEDDAC began receiving casualties. (J. M. Nelson, personal communication, September 5, 1990).

Deputy Commander for Veterinary Services. The Veterinary Service saw a dramatic increase in its food inspection workload during the predeployment period. Veterinary food inspectors worked around the clock evaluating rations. The Deputy Commander for

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Veterinary Services (DCVS) advised the MEDDAC Commander and the Division Surgeon of the expected shelf-life of field rations under extreme temperatures. He also provided advice on methods of shipping and storing rations to enhance shelf-life. The Veterinary Service provided dock-side food inspection for perishables being loaded on the transport ships.

The Veterinary Service performed physicals on all military working dogs prior to the deployment. Several of the dogs were found to be suffering from neglect as their handlers had been diverted to other duties during the predeployment period. The DCVS acted to ensure the dogs, valued at approximately \$30,000 each, would be properly cared for during the Operation. Ultimately, it was decided that neither the dogs nor their handlers would be deployed.

Deputy Commander for Clinical Services. The Deputy Commander for Clinical Services was among the most frustrated members of the MEDDAC staff during the predeployment phase of Operation Desert Shield. He spent a great deal of time with staff physicians, all of whom were concerned about not having time to spend with their units. He indicated that although this MEDDAC and others have PROFIS plans which require them

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to give up practically all of their physicians in the event of a Division deployment, HSC has no plan to backfill the MEDDACs. He argued there should be two PROFIS lists, one indicating personnel from the MEDDACs designated for assignment to field units and another designating personnel to backfill the MEDDACs. (H. A. Weiner, personal communication, August 14, 1990).

Deputy Commander for Administration. The Deputy Commander for Administration (DCA) similarly felt the absence of plans beyond the initial PROFIS list had created unnecessary problems. As he put it, "the hospital delivered on PROFIS, but now what?" Some of the early concerns voiced by the DCA included the need to improve communication between the MEDDAC and its higher headquarters. He noted that communication with both the regional medical center and with HSC had been poor. Looking beyond the immediate situation, the DCA expressed concern for the MEDDAC's ability to support contingencies without support from the Division and with a less-than-full physician staff (the MEDDAC had braced for hurricane Hugo less than twelve months previously). (J. B. Freeman, personal communication, August 13, 1990).

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The DCA addressed the local Rotary Club and other civic groups, updating them on happenings within the MEDDAC. He emphasized that the MEDDAC would indeed remain open. In subsequent days, the DCA frequently entertained questions from community leaders as to the situation at the MEDDAC. Often he could offer them little more than, "we're still here." (J. B. Freeman, personal communication, August 15, 1990).

One of the DCA's major battles during the predeployment phase was fought in an effort to hang on to the MEDDAC's mobilization planner. The mobilization planner, an AGR (active guard/reserve) officer, was scheduled for reassignment to Walter Reed Army Medical Center in September. The DCA felt that it would be a mistake to lose this officer when actual mobilization appeared imminent. Unfortunately, the DCA was unable to convince HSC of this and the mobilization planner departed in September.

The MEDDAC Commander. The MEDDAC Commander is very much a "hands-on" leader. He practiced this leadership style throughout Operation Desert Shield. He was personally involved in the SRP process, in one instance pulling a 24-hour shift at an SRP site. He also took charge of the deployability evaluation

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process. When unit commanders questioned the medical recommendations of a MEDDAC physician, the MEDDAC Commander intervened to make the final medical recommendation. He eventually assumed this responsibility almost entirely. He personally presented many of the classes provided by the MEDDAC to deploying medical personnel. When it became apparent that beneficiaries were concerned about availability of care in the MEDDAC, the Commander personally wrote articles for the post newspaper, cut tapes for television, and gave interviews for the local media.

The Commander's decision-making process appeared similarly straightforward. When a decision was required, he made it. If time allowed, he would convene a meeting with the staff to get their input. When time was short, he did not hesitate to go with the information at hand. For this reason, the Commander repeatedly emphasized to the staff the importance of keeping him informed.

Upon the moment of his return to the MEDDAC on the afternoon of August 7th, the Commander made it clear that the MEDDAC's primary mission was to support the Division's deployment. He became a key member of the installation staff, advising the Commanding General on

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medical issues surrounding the deployment. He took very seriously the role of Director of Health Services at Fort Stewart.

The MEDDAC Commander was extremely concerned by the prospect of sending PROFIS physicians to Saudi Arabia unprepared. He frequently referred to "his 33 sons" that he was sending off to war, occasionally becoming a bit emotional on the subject. He argued that, although it was too late for this group, something had to be done to ensure physicians receive regular field training. He advocates giving MEDDAC's field equipment with which to train. He also believes HSC must come up with some kind of reimbursement system which budgets for physician field training. (C. H. Hood, personal communication, August 13, 1990).

Among the things the MEDDAC did right during the pre-deployment phase, the Commander identified: establishing the Emergency Operations Center (EOC), preparing the PROFIS physicians for deployment, positioning a physician at the SRP site to make deployability recommendations, staffing the Family Assistance Center, assisting the MEDDAC auxiliary in establishing a chain of concern, and successfully anticipating the Division's needs. The Commander noted

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the EOC was necessary as a central information processing station. All correspondence entering or leaving the MEDDAC was logged in at the EOC. All outgoing message traffic was cleared by either the Commander, the DCA, or the DCCS. In this way the Commander felt he was able to maintain control of a very dynamic situation. (C. H. Hood, personal communication, August 13, 1990).

With physicians positioned at each SRP site, questions regarding deployability issues could frequently be settled on the spot. In complicated situations, the physician could refer the patient to the appropriate clinic for evaluation. In considering the staffing of this position, the Commander recommended "a generalist who can cut through the crap." (C. H. Hood, personal communication, August 13, 1990).

The MEDDAC Commander felt it was vitally important that the MEDDAC staff a table at the Family Assistance Center. He saw this as a means through which the MEDDAC could communicate with its beneficiaries and possibly head off some problems before they became

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acute. He emphasized the importance of having people "who know who to call and what to do" at the Family Assistance Center.

When he was not attending meetings, supporting the SRP, or conducting deployability evaluations, the Commander exhorted the staff to keep up the good work. He met several times during the predeployment phase with various staff groups including the physicians, the officers, the enlisted, the civilians, and on at least two occasions, the entire MEDDAC staff. These meetings helped control rumors and gave the staff the assurance of hearing the "straight word" from the "old man."

Situation in the Division

As the divisional units finished loading equipment, their focus shifted to training. Unit commanders emphasized primarily individual and small unit training. One commander got creative, however, taking his unit to the golf course where they maneuvered golf carts, simulating tanks and personnel carriers.

The training was extremely well-received by the soldiers who now recognized the seriousness of the situation they would face in the Middle East. A great deal of emphasis was placed on chemical agent

protective measures. Soldiers spent many hours each day in their protective masks and suits (known collectively as Mission Oriented Protective Posture or MOPP). Although this practice led to an increase in the incidence of heat injuries, it did much to spur the confidence of the soldiers. (W. Norton, personal communication, August 18, 1990).

Misadventures. Throughout the predeployment phase, the Commanding General generally heeded the MEDDAC Commander's advice. However, there were exceptions to this rule, the most notable of which was the Division's large scale purchase of bottled water, insect repellent, aerosol foot powder, and sunscreen from a local retailer. The Division logistics staff made the purchase without first checking with the Installation Medical Supply Office (A. Wilkes, personal communication, March 15, 1991).

Word of the Division's purchases leaked to the press. The following day, reports of the 24th Division's "high-spending ways" hit the newspapers across the nation. A major television network even reported the incident on its nationally-broadcast evening news program. What was not leaked to the press was the Division Surgeon's discovery that the

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manufacturers of the aerosol insect repellent and foot powder warned that these products could explode at temperatures exceeding 120 degrees. Materiel Branch intervened and managed to swap these items for nonaerosol products.

The Division staff recognized the problem it would potentially face in Saudi Arabia with heat injuries and searched for ways to reduce the threat. The plan they came up with was to provide units with gasoline-powered leaf blowers and spray bottles of an alcohol/water solution. If a soldier appeared to be having difficulty with the heat, his peers would spray him with the alcohol/water solution then turn the leaf blower on him. The system reportedly produced a "nice, cooling sensation." The MEDDAC Commander argued vehemently that the use of alcohol as a cooling agent was absolutely unphysiologic and could be dangerous. However, the Division Commander approved the plan and the 24th Division deployed, leaf blowers at the ready.

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VI. Post-deployment Phase

The MEDDAC's mission priorities were rearranged during the post deployment support phase. Prior to the commencement of Operation Desert Shield, the MEDDAC's priorities were: a) providing health care to the local beneficiary population; b) performing various installation support missions; c) conducting ongoing contingency planning; and d) training. The Army's semi-wartime posture brought about by Operation Desert Shield was now reflected in the realignment of the MEDDAC's priorities. The top priority had clearly become that of supporting the installation in any and all mobilization and deployment related activities. The other missions in descending priority order were: training, contingency planning, and care to the beneficiary population.

The change in the MEDDAC's mission priorities was driven by the dramatic environmental change created by Operation Desert Shield. This is not to say that the MEDDAC was a passive participant--it was not. Rather, it indicates that these priorities were dictated by the situation. By recognizing and readily accepting these

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new priorities, the MEDDAC enhanced its ability to successfully fulfill its role in support of the Operation.

Installation Support Functions

The Soldier Readiness Process. The SRP was a key function performed during the predeployment phase. However, the departure of the 24th Division did not end the requirement for Soldier Readiness Processing. After the departure of the two active brigades of the 24th Division, the 197th Infantry Brigade (M) from Fort Benning arrived with its 3,000 plus soldiers for deployment preparation. Five thousand soldiers from the 48th Brigade of the Georgia Army National Guard followed the 197th. Many smaller units, both active and reserve, deployed through Fort Stewart. All of these units were ushered through the installation SRP. As it turned out, the 16,000 soldiers who initially deployed with the 24th Division comprised less than half of the total number which would be processed through Fort Stewart.

The MEDDAC designed, staffed, and supplied the medical portion of the SRP. Support to the SRP required a large commitment of resources by the MEDDAC throughout the post-deployment phase.

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The MEDDAC Commander was intimately involved in the SRP support mission. He attended installation staff meetings and personally coordinated many of the SRP requirements. With the input of various MEDDAC sections, he designed and modified the medical portion of the SRP. He determined staffing requirements and occasionally even developed the schedules for physician coverage. The Commander was also on the physician rotation schedule supporting the SRP throughout the Operation.

Ambulatory Care Nursing Service provided staff oversight for the medical portion of the SRP. Staffing and managing the SRP continued to occupy a significant portion of the Ambulatory Care Nursing Service workload during the post-deployment support phase.

Clinical Support Division, in coordination with the Deputy Commander for Clinical Services, maintained the roster for physician staffing at the SRP. As could be expected, this was a difficult undertaking. It was further complicated by the turnover of physicians which resulted as backfill physicians arrived and later as activated reserve physicians arrived and backfill physicians were released.

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The problem of physician turnover, compounded by irregular SRP requirements, made managing clinic schedules almost impossible. The Chief of CSD coordinated closely with the Chief of Ambulatory Care Support Branch to minimize disruption of appointment schedules. Unfortunately, disruptions were frequently unavoidable and appointments were often cancelled and rescheduled.

Logistics Division, functioning as the Installation Medical Supply Activity (IMSA), continued to support the medical supply needs of the SRP. Logistics Division overcame the difficulties encountered in the early phases of the SRP. This was done by maintaining regular coordination with PTMS and the MEDDAC Commander during the planning stages of upcoming SRPs. Close communication was maintained with Ambulatory Care Nursing Service during the actual performance of the SRP. These actions enabled Logistics Division to accurately project medical supply needs and to ensure the items were in place when needed.

The MEDDAC's goals for the SRP were three-fold:
a) to ensure soldiers met Army requirements for deployment, b) to identify soldiers with performance

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limiting conditions, and c) to do it all very quickly, creating the least possible disruption in unit training schedules (C. H. Hood, personal communication, March 18, 1991). To meet these goals, the medical portion of the SRP was refined between the time of the deployment of the 24th Division and subsequent deployments by other active and reserve units.

The medical portion of the SRP consisted of eight stations: In-briefing, medical records issue, blood draw, immunizations, optometry, audiology, checklist review, and physician screening. The process began when platoon-sized units of 25 to 60 soldiers entered the SRP site (usually a gymnasium) and were briefed as to what would occur. The in-brief was generally conducted in the bleachers near the entrance to the SRP line. At this point, unit leaders were offered an opportunity to talk briefly with their soldiers and make any important announcements.

Soldiers proceeded from the in-brief to a records table where medical records were issued. If a soldier did not have a medical record, one was created using the HSC Form 621-R, Individual Medical History. HSC approved this form for use shortly after the beginning of the predeployment phase. Use of the Individual

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Medical History form expedited the processing of soldiers who did not have their medical records.

The next station was the blood-draw table where blood samples were taken for HIV and Beta HCG tests. HIV tests were performed only for those soldiers without a current HIV test. Beta HCG tests were performed on all females to rule out pregnancy.

At the immunization station, shot records were screened and immunizations were given. A maximum of seven immunizations was required, although most soldiers needed only two or three. In no cases were soldiers given more than four immunizations in one day. Female soldiers were not given immunizations which could pose a threat to an unborn fetus (live agent vaccines) prior to completion of the Beta HCG test. These soldiers, as well as those requiring repeat immunizations to complete a series, were scheduled for re-immunization. This was done by the noncommissioned officer in charge (NCOIC) of the immunization station who notified unit leaders and coordinated re-immunizations. In some cases, The MEDDAC sent immunization teams to ranges and other training areas to minimize the disruption to unit training.

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Soldiers continued from the immunization station to the optometry station where prescriptions were verified and spectacles and protective mask inserts were ordered as required. At the audiology station, audiograms were reviewed and soldiers were fitted with ear plugs.

After the audiology station, soldiers presented their SRP checklists to a senior medical noncommissioned officer (NCO). The medical NCO reviewed the checklists to verify that the soldier had completed all stations.

A physician reviewed medical records and interviewed each soldier at the final station. If no problems were evident, the physician signed the checklists completing the medical portion of the SRP. If a problem did arise, the physician could refer the soldier to a senior physician, located on-site, for his disposition. The screening physician could also refer the soldier to an internist or an orthopedist, both of whom were also on-site. If lab or other testing or evaluation was required, the physician could refer the soldier to the appropriate clinic in the MEDDAC. In such cases, soldiers were transported to and from the MEDDAC in a patient transport vehicle. At the MEDDAC

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they were given priority attention and returned to the SRP site as quickly as possible.

Approximately 21 to 25 members of the MEDDAC staff were committed to each SRP site. During the predeployment phase and during periods of heavy mobilization activity, two SRP sites were staffed around the clock. SRP staffing included physicians (two screeners, two specialists--an internist and an orthopedist--and a senior physician), nurses and enlisted medical technicians at the immunization station and blood-draw table, optometry technicians and an optometrist, audiology technicians and an audiologist, medical records technicians, and support personnel.

At the completion of a unit's SRP, the unit commander was given a printout indicating the medical recommendation pertaining to each of his or her soldiers. The printout was generated from a laptop computer operated at the screening physicians' table. The printout listed unit members by name and last four digits of their social security number. Beside each name was the result of a decision matrix indicating "yes" the soldier was medically deployable, "no" the physician recommended against deployment, or "needs

"work" followed by a time estimate within which the physician felt the medical problem could be corrected and the soldier returned to a fully deployable status. The objective was to provide each unit a printout by the end of the day on which they began the process.

The medical portion of the SRP processed large numbers of soldiers in relatively short periods of time. By operating two sites around the clock, the MEDDAC staff processed the entire 48th Infantry Brigade (approximately 5,000 soldiers) in 72 hours.

The MEDDAC Commander attributed the MEDDAC's success to the hard work of his staff and to an understanding of the philosophy of medical readiness processing. As he notes:

.. The philosophy is crucial. How do you provide proper medical processing for a bunch of troops who are going in harms way, with protection for the taxpayer who doesn't need a whole bunch of liability claims to grow out of sloppy processing, and yet at the same time with protection for the unit which must train and cannot be bogged down with medical [processing] for days and days?

...The best way to do it is to resource a "conga line" of people and at each point along the way a

decision point is reached and as that decision point is reached and passed it is checked off so that you can go back, if you must, and pick-up the ones and twos at a later time. (C. H. Hood, personal communication, March 18, 1991).

Deployability evaluations. The MEDDAC performed medical evaluations for deployability throughout the post-deployment phase. This required a significant time commitment, particularly on the parts of the Commander and other senior physicians.

Soldiers with potentially deployment limiting medical problems were sent to the MEDDAC for a thorough evaluation. Initially these evaluations were done by staff physicians who then made recommendations to the unit commanders. The unit commanders, who have final decision-making authority on questions of deployability, were frequently reluctant to go along with the physicians' recommendations. In many cases, they appealed to the MEDDAC Commander to personally evaluate a soldier in question.

Personnel strength was a major issue for deploying units. Commanders were under tremendous pressure to achieve and maintain the highest readiness posture. The MEDDAC Commander recognized the sensitivity of the

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personnel strength issue and the impact medical deployability recommendations had on it. For this reason, he decided to personally screen all soldiers identified with potentially deployment-limiting conditions.

The MEDDAC Commander devoted a tremendous amount of his time during the post-deployment period to performing deployability evaluations. He held an ad hoc medical clinic in his command suite office. Chairs placed in the hallway outside his office were regularly filled by soldiers awaiting an evaluation. The Commander's secretary became a de facto clinic receptionist, making appointments, scheduling referrals, handling records, and typing deployability recommendations. When the Commander was not available, the Deputy Commander for Clinical Services performed the deployability evaluations.

The MEDDAC Commander became the Fort Stewart authority, by position and by direct experience, on the subject of medical deployability issues and soldier fitness in general. By personally conducting the deployability evaluations, he could respond directly to questions from unit commanders about the status of their soldiers. He could also advise the Installation

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Commander, and through the Installation Commander, the Commanding General, about the medical readiness of deploying soldiers. The MEDDAC Commander felt his personal commitment to the deployability evaluations greatly enhanced his ability to function effectively as the Director of Health Services. (C. H. Hood, personal communication, February 27, 1991).

Medical supply. The medical supply mission continued to be a key function of the MEDDAC in supporting the installation during the post-deployment period. The MEDDAC's Logistics Division "fine-tuned" its procedures and provided quality medical logistics support to units deploying from Fort Stewart.

The Installation Medical Supply Activity (IMSA) mission did not constitute a new requirement for the MEDDAC. Logistics Division is the IMSA during peacetime operations. As the TMSA, Logistics Division issues to the MEDDAC and the Division Medical Supply Office (DMSO). With the departure of the DMSO, Logistics Division assumed the role of interfacing directly with the "retail" customers. This was a new requirement, but one to which the Logistics Division readily adapted.

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Materiel Branch handled the new direct medical supply mission. Medical personnel from deploying units came directly to Materiel Branch with their Department of Army Forms 2765-1, Request for Issue of Supplies. Materiel Branch maintained a document register with which to account for medical supplies issued to deploying units. Supply requests were received, the document register annotated, and the supplies issued. The process was very smooth and quite similar to that used by the DMSO prior to its departure.

Materiel Branch noted that many units were not sure what supplies they needed. This was particularly true for units without assigned medical personnel. Materiel Branch helped units identify their requirements and developed a standard issue list for units without assigned medical personnel. Through this and other services, Materiel Branch became a ready and frequently called upon source of advice and assistance to deploying units.

Troop Medical Clinic support. With the departure of the Division Surgeon and the division medical assets, full responsibility for the Troop Medical Clinics (TMCs) fell to the MEDDAC. Ambulatory Care Nursing Service was given staff responsibility for the

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TMCs. Non-deployable enlisted medical personnel from the Division were attached to the MEDDAC and placed in Ambulatory Care Nursing Service. For the most part, it was these soldiers who staffed the TMC.

The three TMCs were consolidated into a single TMC located on the southern part of the garrison (the area of the highest troop concentration). After the deployment of the Division, troops remaining on post were reassigned to a provisional battalion and moved into common billets located on the northern part of the garrison. As reservists began to arrive, they too were assigned to billets located in the northern area. Ambulatory Care Nursing Service soon discovered that the location of its TMC was now inconvenient to the troop population. Therefore, during the post-deployment period, the TMC was relocated to improve access for the soldiers.

Staffing the TMC was an ongoing problem for Ambulatory Care Nursing Service. True, Ambulatory Care Nursing Service had gained the Division's nondeployable medical soldiers. This turned out to be both a blessing and a curse, however. The nondeployable soldiers were nondeployable for a reason, and for many this meant repeated medical appointments and other

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requirements which took them away from their jobs. Of the seven Division medics used to staff the TMC, one or more could be expected to be away from work on any given day.

The total staff of the TMC consisted of an NCOIC and seven enlisted medics from Ambulatory Care Nursing Service and anywhere from one to three physicians (depending upon other requirements and current physician staffing) coordinated by Clinical Support Division. The staff supported a workload of approximately 70 patient visits a day throughout the post-deployment period. The TMC operated from 7:00 A.M. until 4:00 P.M. Monday through Friday. On weekends, soldiers used the MEDDAC's emergency room for sick-call. (A. Hussain, personal communication, March 20, 1991).

Range coverage and other missions. In addition to the TMC mission, Ambulatory Care Nursing Service picked up many other installation-support missions. Most notable among these is the range-coverage mission.

Units mobilizing at Fort Stewart spent every available minute training. Much of their training time was spent on the various firing ranges scattered across Fort Stewart. Because medical coverage is required on

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all ranges, medical personnel had to be present before a unit could use a firing range. This created a problem for those units without assigned medical personnel. The solution to the problem required the unit to request medical support through the installation Directorate of Plans and Training (DPT) who forwarded the request to PTMS at the MEDDAC. Plans, Training, Mobilization, and Security logged the request then sent the tasking to Ambulatory Care Nursing Service. The NCOIC of Ambulatory Care Nursing Service then contacted the requesting unit and coordinated the medical support. Typically, the unit would pick up the medic at the hospital prior to going to the range. The medic was equipped with an aid bag and a litter.

Providing range coverage was a problematic but manageable requirement for Ambulatory Care Nursing Service. Supporting this requirement often proved frustrating due to the frequency of "short-fused" requests and unit no-shows. Although the MEDDAC's policy required that units make their requests for medical support at least 24 hours prior to the

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scheduled training, this frequently did not occur. Requests for medical support were often received with as little as six to eight hours of lead time or less.

The MEDDAC "bent over backwards" to support requests for medical support. Doing so often created turmoil in clinic staffing schedules and occasionally meant that a clinic had to operate short of personnel. The MEDDAC, and Ambulatory Care Nursing Service in particular, understood the seriousness of the mission these units faced and was committed to supporting them. Medical support requests were honored, even when the "24-hour rule" was violated.

While the MEDDAC continued to support unit requests for medical support at almost all costs, the units frequently did not show-up. In an estimated 20 to 30 percent of the cases, the units did not pick-up their medics as had been prearranged, nor did they call to cancel the requirement. (A. Hussain, personal communication, March 20, 1991).

Ambulatory Care Nursing Service was heavily involved in supporting many other missions including: the SRP, welcome center in-processing activities, dockside activities, Tuttle Army Health Clinic, and the Primary Leadership Development Course (PLDC).

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Ambulatory Care Nursing Service provided personnel staffing and oversight for the immunization station of the SRP. It provided similar support to the welcome center where daily in-processing and basic SRP activities were conducted. Ambulatory Care Nursing Service continued to provide medical support as needed to the Port of Savannah for periodic ship-loading activities. Additional staffing was required for Tuttle Army Health Clinic at Hunter Army Airfield during troop staging and deployment operations which continued throughout much of the post-deployment period. The final significant additional mission which Ambulatory Care Nursing Service picked-up was support to the PLDC. Two enlisted medics were attached to the PLDC to provide 24-hour-a-day coverage for a period of eight days. Ambulatory Care Nursing Service rotated the PLDC medical team after each eight-day period. (A. Hussain, personal communication, March 20, 1991).

Psychiatric assistance. The MEDDAC's Community Mental Health Activity was very active in providing assistance to both deploying soldiers and their families. The services offered included: Family separation and stress management classes given throughout the post-deployment period to various wives

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groups, consultations with chains of concern and key leaders regarding individual cases, counseling and evaluation of family members, and inpatient treatment.

The Social Work Section was particularly active during the post-deployment period, meeting with wives groups many nights each week. These community education and family support missions were new to the MEDDAC's Social Work Section. Prior to the deployment, this section had provided individual counseling and evaluation services and group rehabilitation sessions. While these routine activities continued, the additional community support services required the staff of Social Work Section to frequently extend their schedules late into the evening.

The Social Work Section emphasized a wellness orientation in all the services it provided. According to the section chief, "Everything we did focused on increasing the ability of the individual to function and cope with the rigors of daily life" (D. F. McFerran, March 21, 1991).

Many of the psychiatric problems noted during the post-deployment phase were, not surprisingly, adjustment disorders. Adjustment disorders were manifested in both mobilizing reservists and family

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members through mixed emotional responses. While many expressed anger and exhibited violent behavior, the more common response was depression.

Adjustment problems requiring hospitalization were quite high among mobilizing reserve units.

Interestingly, such problems appeared more prevalent among Army Reserve units than among Army National Guard units. Frequently, suicide gestures of mild overdoses and "scratched wrists" were the events leading to hospitalization. Suicide gestures were on the increase among mobilizing units until two soldiers were turned over to the military police and placed in the stockade as malingerers. Subsequently, a notable decrease in the incidence of suicide gestures was noted. (J. Taylor, personal communication, March 21, 1991).

Among wives of deployed soldiers, two distinct types of emotional responses were noted. The first was a mild adjustment disorder resulting from a reliance on the now-deployed spouse. With the significant other gone, the dependent spouse began to deterioriate emotionally. The incidence of this disorder increased with time. The second type of response was a resurgence of grief reaction. Many patients were seen suffering from a resurgence of suppressed grief from

the childhood trauma of abuse or incest. For others this manifested from the overwhelming realization that the deployed spouse might not come back. (J. Taylor, personal communication, March 21, 1991).

The post-deployment period was a stressful time for all spouses of deployed soldiers. For many, the stressors of single parenthood or loneliness compounded by concern for the deployed spouse became too much. Others managed to keep things together and continue with their lives. However, both groups, the healthy and unhealthy, agreed that the single biggest stressor was the lack of a time boundary. In the Vietnam situation, families knew their loved one would be gone for one year and could focus on a specific date of return. During Desert Shield the spouses did not have this comfort. They could not look at a calendar and anticipate seeing their spouse again at a certain point. Spouses repeatedly expressed frustration at not being able to set a date and say, "if I can just make it to then, we'll be back together and I'll be Okay." (J. Taylor, personal communication, March 21, 1991).

Training Activities

Training is an important activity in all military units. Informal, on-the-job training exists

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continually in the MEDDAC. However, in the MEDDAC, as in all military medical facilities, training in combat-support functions has become secondary to patient care and activities supporting the provision of patient care.

With the initiation of Operation Desert Shield, combat-related training took on new significance. Unfortunately, without weapons, protective masks, or any other field equipment, the MEDDAC was able to offer its staff very little combat-oriented training.

As Operation Desert Shield progressed, the MEDDAC looked for innovative ways in which it could assist mobilizing units with medical training and offer some type of preparatory training to its staff as well. Among the training programs the MEDDAC offered during the post-deployment support phase were: The Combat lifesaver Course, the Advanced Trauma Life Support Course (ATLS), the Advanced Cardiac Life Support Course (ACLS), a series of casualty preparedness classes, and cardiopulmonary resuscitation (CPR) classes.

Combat Lifesaver Course. Among the most valuable services the MEDDAC offered units mobilizing at Fort Stewart was the Combat Lifesaver Course. Presented by Nursing Education and Staff Development (NESD), the

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MEDDAC Combat Lifesaver Program eventually graduated 269 students.

The MEDDAC Combat Lifesaver Course was taught by experienced enlisted soldiers who were detailed to NESD for the period of the training. The instructors were selected from the MEDDAC staff based upon their unique qualifications. The instructors were all Emergency Medical Technician (EMT) qualified and had completed, and in some cases taught, the Basic Life Support Course and the Advanced Cardiac Life Support Course. Two of the three instructors had taught the Combat Lifesaver Course elsewhere and all had served in field units during previous assignments. (S. B. Dessasure, personal communication, March 22, 1991).

The MEDDAC's Combat Lifesaver Course had a capacity of 30 students per class and was offered weekly beginning November 5, 1990. The demand for the course was such that the 48th Infantry Brigade contracted for civilian medical personnel to offer an additional class. Although this group used the Combat Lifesaver lesson plan, the training was judged substandard. The contract was terminated after two classes.

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Interest in the Combat Lifesaver program intensified as the threat of war increased. The potential need to actually initiate intravenous infusions, apply pressure dressings, and perform cardiopulmonary resuscitation was now real. Commanders consistently sent good, motivated soldiers to the course. The pass rate was 100 percent. Feedback from course participants and unit commanders indicated the training was very well received.

Every Friday afternoon the program graduated a class of 30 new combat lifesavers. A copy of the attendance roster was sent to the MEDDAC's Materiel Branch where combat lifesaver bags were issued to all graduates.

- The Advanced Trauma Life Support Course. Early in the post-deployment period, the MEDDAC Commander began planning for an ATLS course he hoped to offer the medical staff prior to the initiation of hostilities in Southwest Asia. The Joint Medical Readiness Training Center (JMRTC) was contacted and agreed to provide the course. A vacant dining facility located on Camp Oliver, an isolated sub-post of Fort Stewart, was identified as the location for the training. The Deputy Commander for Veterinary Services acquired

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laboratory goats, cared for them, and disposed of the remains. Thirty support personnel were detailed and the course was held on the weekend of January 25-27, just after the outbreak of hostilities.

Fifty MEDDAC staff members attended the course. Participants were primarily physicians, although nursing personnel from the Anesthesia Service, the Operating Room, and the Emergency Room also attended. Forty-seven passed the written exam and all passed the practical, hands-on portion of the test. Once again, this training was very well received.

Advanced Cardiac Life Support Course. The Advanced Cardiac Life Support Course was offered on December 9-10, a Friday and Saturday. The course was taught by the Chief of the MEDDAC's Ambulance Section, an experienced ACLS instructor. The 25 attendees were primarily from the nursing staffs of the Emergency Room, Intensive Care Unit, and various wards.

Casualty preparedness courses. A series of 24 casualty preparedness courses representing 29 continuing education units was offered during a one-week period in January. The classes dealt with such issues as management of burns, IV therapy, ostomy care, management of penetrating injuries, care of

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chemical injuries, fluid balance, and other acute care subjects. The classes were offered under the staff supervision of NESD and were presented by physicians, nurses, enlisted members, and civilians. The courses were accredited by the Georgia Nurses Association. They were directed primarily at the nursing staffs of the outpatient clinics, the Labor and Delivery Unit, Newborn Nursery, Post-partum Ward, and Pediatric Ward, as well as any other staff members who felt the need to get back up to date in any of the respective areas. The total attendance registered for all classes was 567.

Cardiopulmonary Resuscitation. The 345th USAR Combat Support Hospital mobilized at Fort Stewart and required validation by the MEDDAC. During the validation process, a large percentage of the 345th's staff was found to be delinquent in CPR. An all-day CPR training and testing session was subsequently held for approximately 100 staff members from the 345th hospital.

Contingency Planning

Contingency planning is an activity that goes on continuously as organizations attempt to anticipate and prepare for change. The MEDDAC conducted both formal

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and informal contingency planning prior to the onset of Operation Desert Shield. The MEDDAC's Emergency Preparedness Plan and its Mobilization Expansion Plan are examples of formal contingency plans. Plans, Training, Mobilization, and Security Division is responsible for formal contingency planning. Informal contingency planning occurs on a daily basis as the MEDDAC Commander and staff members think about the future and meet to discuss and plan for potential situations.

The PROFIS plan. The situation presented by Operation Desert Shield was not thoroughly anticipated and contingency plans failed to cover many of the issues which arose. A good example was the failure of the Professional Officer Filler System (PROFIS), a formal contingency plan developed by HSC, to provide a formal mechanism for physician backfill. That such an important plan could exist with such a major flaw is indicative of the attention given to contingency planning by the Army Medical Department during previous years.

The drive in recent years to pull military medicine into line with civilian health care has focused contingency planning efforts away from

military-specific issues such as PROFIS. The contingency plans most heavily scrutinized are those mandated by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO). Plans to support a deploying military force do not fall within the purview of JCAHO. Consequently, these plans have been neglected.

Semi-formal contingency planning. The MEDDAC operated through much of the predeployment phase in a reactive mode. But with the departure of the Division, the MEDDAC had a chance to catch its breath and look ahead. Under the direction of the Commander, the MEDDAC staff began conducting "semi-formal" contingency planning. The semi-formal planning process typically began when the Commander recognized a potential contingency and directed the staff to consider what it could mean to the MEDDAC and recommend an appropriate response. The staff would spend the next 24 hours researching the issue and meeting to work-out details. The group would return and brief the Commander who would approve the plan as recommended, modify it, or reject it and either direct a mode of operation or send the staff back to the drawing board. The final product of such semi-formal planning sessions was a written

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plan, or in some cases, simply an understanding among staff sections as to the method for handling a certain contingency.

Using this mode of planning, the MEDDAC planned for an array of contingencies which had been largely overlooked in previous years. Among these were: Physician staffing under conditions of mobilization; mobilization support at Fort Stewart and Camp Blanding, Florida; casualty reception; expansion; emergency preparedness; blood collection; operation as a rehabilitation or convalescent center; and handling and disposition of remains.

Physician staffing plans. Upon the initiation of predeployment activities, the MEDDAC Commander planned to discontinue most hospital operations. Since the PROFIS system makes no provisions for staffing MEDDACS which lose most of their physicians to a deployment, he did not expect to have sufficient physicians to continue the mission. Shortly after the alert, the 24th Division Commander, followed by the Vice Chief of Staff of the Army, made it very clear that this would not happen. At that point, the MEDDAC Commander and staff began planning to staff the MEDDAC to continue its mission. Initially, this required use of deploying

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physicians. Later, it required integration of active-duty backfill physicians, followed by release of the "backfills" and integration of volunteer and mobilized Army Reserve physicians.

The Deputy Commander for Clinical Services, assisted by the Chief of Clinical Support Division, monitored and coordinated physician staffing. The DCCS worked closely with the Commander to ensure physician arrivals and departures were handled in such a way as to minimize turbulence. With the assistance of Personnel Division, physician vacancies were forecast and needs forwarded to HSC.

The staff anticipated the call-up of Army Reserve units and planned for the arrival of the 3297th U.S. Army Reserve Hospital with its physician staff. The MEDDAC drew on its experience from receiving backfill physicians as it planned to receive and integrate the 3297th physicians. The MEDDAC scrutinized the 3297th's manning roster, matching specialties and planning assignments. Credentialling activities were planned (and begun to an extent) prior to the unit's arrival. Key orientation issues were identified and a clinical orientation seminar was prepared. The Chief, CSD; DCCS; and Commander tried to project the services the

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MEDDAC would be able to provide with the mobilized reserve staff. Plans to delete, decrease, or supplement services according to physician staff were made and in some cases carried out. The MEDDAC did not communicate its projected capabilities to the local population due to the uncertainty which continued to surround the staffing issue.

Mobilization support at Fort Stewart and Camp Blanding. The MEDDAC's success in supporting the mobilization of large numbers of active and reserve units is due largely to the planning it conducted for these activities. The Commander and each staff section involved in the SRP identified ways to improve the process and planned various staffing contingencies based upon the numbers to be processed. A team was sent to Camp Blanding, a mobilization site in north Florida, to inspect it and provide input to MEDDAC mobilization support plans. That the MEDDAC had plans to support mobilization activities at Camp Blanding, which was not used, is indicative of the attention mobilization planning received during Operation Desert Shield.

Casualty reception. Fort Stewart was initially designated a primary casualty receiving center. Later

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it was designated a secondary casualty receiving center with Eisenhower Army Medical Center serving as the primary regional receiving center. Nonetheless, the MEDDAC planned extensively for the casualty receiving mission. It requested ambulance buses and the necessary conversion kits for them. Training was conducted in procedures for loading ambulance buses and staff members with bus driver's licenses were identified. Plans were made to upgrade Tuttle Army Health Clinic for patient holding in the event patients arriving at Hunter Army Airfield could not be immediately transported to Fort Stewart. Initial plans were made for liaison with Navy, Air Force, Veterans Affairs, and civilian National Disaster Medical System (NDMS) hospitals.

Expansion plans. The MEDDAC's expansion plans were closely scrutinized throughout Operation Desert Shield. Plans were made both for in-house expansion and for expansion into buildings adjacent to the MEDDAC. Based upon widely varying casualty estimates, the MEDDAC planned to support expansion missions ranging from 200 to over 500 patients.

Although initial expansion plans had already been made, the MEDDAC refined its plans upon receipt of a

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message from HSC requiring it to identify in-house expansion capabilities and equipment requirements. The Department of Nursing and Logistics Division were heavily involved in performing this task.

The MEDDAC was not required by HSC to identify personnel requirements to support expansion. However, the Commander directed that the MEDDAC staff consider personnel requirements to support both in-house and out-of-house expansion contingencies. The staff also considered logistics, transportation, feeding, safety, and quality of care issues inherent in potential expansion scenarios. The MEDDAC prepared a formal plan to support in-house expansion, a semi-formal plan to expand into buildings adjacent to the MEDDAC, and informal plans for various alternative use scenarios.

Rehabilitation/convalescent center. One of the alternative scenarios the MEDDAC anticipated was operation as a rehabilitation or convalescent center. After HSC indicated that medical centers would be primary receiving centers and the MEDDAC would be a secondary center, the Commander directed the staff to consider the potential of operating largely as a convalescent center. He felt the regional medical center would handle most of the acute care needs,

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returning patients to the MEDDAC when they were stable and required primarily convalescent and rehabilitative care. The staff made informal plans to support an expansion mission consisting largely of patients requiring such care.

Blood collection. The MEDDAC has the mobilization mission of blood collection. The installation mobilization plan recognizes the blood collection mission and designates the Youth Activities Gymnasium as the site for blood collection operations.

With the onset of Operation Desert Shield, the MEDDAC Laboratory Manager began planning to effect the blood collection mission. He used the floor plans of the Youth Activities Gymnasium to identify necessary modifications and to plan the layout of the blood collection center. On December 5, 1991, the MEDDAC was ordered to prepare to activate its blood collection center. The Laboratory Manager passed his request for building modification to the installation Directorate of Engineering and Housing (DEH) and contacted the Directorate of Personnel and Community Activities to coordinate occupation of the building. The DPCA refused to vacate the building citing essential youth programs which could not be discontinued.

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During preparation of the installation's mobilization plan, the Directorate of Logistics (which "owns" the building) had committed the youth gym for use as a blood center. This apparently had not been coordinated with the DPCA. Consequently, it fell to the MEDDAC to find another location for its blood collection center. The DEH indicated it had no other buildings suitable for blood collection purposes. In coordination with the MEDDAC Commander, the Laboratory Manager identified a vacated TMC and prepared it to support the blood collection operation. The blood collection center was subsequently established and put into operation from this location. (J. T. Brazell, personal communication, March 22, 1991).

Staffing the blood collection center proved problematic. Personnel requirements for the blood collection center were identified in the MEDDAC's Mobilization Table of Distribution and Allowances (Mob TDA). However, the MEDDAC was precluded from hiring civilians against the Mob TDA until the President declared full mobilization. Since this never occurred, the MEDDAC hired temporary civilian employees and allocated the cost against the Desert Shield account processing code (APC). As the Operation progressed,

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additional military personnel from mobilized Army Reserve Troop Program Units (TPUs) arrived to support the blood collection center. (J. T. Brazell, personal communication, March 22, 1991).

Emergency preparedness planning. With all the attention focused on planning to support Operation Desert Shield, there was a real possibility that planning for unrelated contingencies would be overlooked. This was not the case, however. Shortly after the onset of Desert Shield, the Commander directed that the staff review the Emergency Preparedness Plan (EPP) giving consideration to the absence of the Division. The MEDDAC's EPP draws heavily upon the Division to help support various contingency operations. The Division's absence required that the MEDDAC reconsider its plans to support local emergencies. Plans, Training, Mobilization, and Security Division coordinated the EPP review. Based on staff input, PTMS coordinated the modified MEDDAC EPP support requirements with the installation Directorate of Plans and Training.

Disposition of remains. One final example of contingency planning, listed here to demonstrate the depth of planning which occurred during Operation Desert

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Shield, is plans for disposition of remains. The Commander directed that Logistics Division identify the MEDDAC's capacity to hold cadavers and to review plans for disposition of remains. Logistics Division identified the MEDDAC's holding capacity and, after consultation with HSC, formalized plans to expand the MEDDAC's capacity with a refrigerated trailer. Patient Affairs Branch, of Patient Administration Division, reviewed procedures for disposition of remains with the installation Mortuary Affairs Officer.

Care for the Local Population

The provision of health care to the local beneficiary population assumed a lower priority during Desert Shield than it received in peacetime. As the MEDDAC prepared to deploy its physicians, interruptions in care were unavoidable. The MEDDAC's ability to meet the needs of the local population continued to fluctuate during the post-deployment phase. With the turbulence of integrating backfill physicians, integrating reserve physicians, releasing backfill physicians, and the resultant specialty mismatches and occasional shortages, consistency was simply not possible.

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In spite of this difficult situation, the MEDDAC had obligations to meet. The Division Commander and Vice Chief of Staff of the Army had assured the Fort Stewart community that health care for families of deployed soldiers would be a priority. Later, the HSC Commander issued a memorandum indicating that continued care to family members was essential (Major, August 11, 1991). Clearly, care to family members had to be maintained.

The MEDDAC adopted a policy of doing all it could to meet the needs of all beneficiaries, while prioritizing support of the deployment and care to active duty members. Frequently, clinics offered only same-day appointments because physician schedules could not be projected beyond one day in advance. As backfill physicians arrived, clinic schedules became a bit more predictable. A situation of reduced capacity persisted due to lower physician staffing and continuing SRP requirements. As reserve physicians joined the staff, the capacity picked-up and generally met or exceeded that which existed prior to the deployment (Medical Corps officer staffing ultimately exceeded 120 percent of authorizations while Army Nurse Corps staffing approached 200 percent).

With the departure of the Division and many dependent families, a reduction in the demand for health care services might have been expected. In most cases, however, the MEDDAC did not feel this drop in demand. Obstetrics was the exception to this rule. Prior to the deployment, approximately 120 babies were delivered at the MEDDAC each month. After the deployment, this number fell to approximately 80 per month. The reduction in deliveries translated to a lower inpatient census and reduced demand for obstetrical and pediatric clinic services. These clinics were able to reduce their appointment backlogs as a result of the lower demand.

Management Challenges

Operation Desert Shield presented MEDDAC leaders a number of management challenges. First among these was the need to reestablish the MEDDAC's priorities. Personnel management, including management of backfill physicians, integration of reservists, and utilization of nursing personnel was another challenge MEDDAC leaders faced. Finally, meeting all aspects of their four-part mission--providing medical personnel to deploying units, providing undiminished care to family members, providing medical logistics support to

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deploying units, and preparing to receive and treat casualties of war--was the single most significant challenge imposed upon MEDDAC leaders.

Realignment of priorities. The MEDDAC's priorities clearly changed during Operation Desert Shield. As discussed at the beginning of this chapter, support for deploying forces had become the primary mission. Contingency planning and training received increased emphasis, while care to non-active duty personnel slipped in importance.

The MEDDAC Commander repeatedly explained the MEDDAC's new priorities to the staff. He met frequently with various staff groups and, on two occasions, with the entire staff during the early days of the predeployment phase. During these meetings, the Commander tried to focus the staff's attention on supporting the deployment. He repeatedly explained, "we have only one job, soldier support, everything else is secondary" (C. H. Hood, personal communication, August 9, 1990).

While soldier support received primary emphasis, other aspects of the MEDDAC's mission were not completely neglected. Interest in training was rekindled by the knowledge that the MEDDAC could soon

be called upon to treat casualties of war. Training also served to occupy nurses idled by the drop in workload and concomitant increase in nursing staff due to the arrival of reservists. Contingency planning was an ongoing activity often spurred by "what if" scenarios cast by the MEDDAC Commander.

The continuation of care to family members and other local beneficiaries received notably less attention. Although the HSC Commander listed care to family members alongside support to deploying forces in HSC's mission priorities, this was viewed as simply not practical. Upon receipt of the message detailing HSC's mission priorities, the MEDDAC Commander began citing family member care as a priority for the MEDDAC. However, neither HSC nor the MEDDAC's actions supported the notion that family member care was equal, or near equal, to support for soldiers. While directing the MEDDAC to provide support to the deploying forces and also continue family member care. HSC was slow in providing backfill physicians and refused to release with contract dollars which the MEDDAC could have used to supplement its capacity. Consequently, while the MEDDAC said family member care was a priority, it was regularly interrupted throughout Operation Desert

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Shield when SRP, deployability evaluations, or other deployment related issues arose. Clearly, it was politically necessary to say family member care was a priority and to make an effort to provide it. The truth, however, was that family member care was fourth on the MEDDAC's priority list.

Personnel management. Managing personnel resources during the turbulence created by Operation Desert Shield was a challenge in the truest sense of the word. Requirements for physicians rarely matched their availability during the predeployment phase. Turbulence in physician staffing continued well into the post-deployment phase. Utilization of the increasingly abundant nursing personnel presented a management challenge of another type. The situation was simply one of not enough physicians and too many nurses.

As PROFIS physicians began to depart and were replaced by active-duty backfill physicians, the DCCS and Chief of CSD found it necessary to produce a daily PROFIS backfill physician staffing roster. This was an informal document which simply listed the backfill physicians on-staff or due to arrive. The MEDDAC was in frequent contact with HSC trying to determine when

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backfill physicians could be expected in order to project clinic capabilities. Clinics operated on a one-day appointment schedule throughout much of the predeployment phase and the early days of the post-deployment phase, reflecting the difficulty of projecting physician availability and deployment support requirements.

When backfill physicians did arrive, issues of housing, transportation, and telephones had to be addressed. Backfill physicians were housed in the Bachelor Officers Quarters (BOQ) located approximately one-half mile from the MEDDAC. Many spent their first night or nights in a local hotel (or in the case of four physicians, in the MEDDAC) waiting for BOQ rooms to become available. Many of the backfill physicians brought their own cars with them, thus eliminating any transportation problems. Transportation, in the form of the EOC van, was available to other backfill physicians as needed. However, due to the proximity of the BOQ to the MEDDAC, many physicians simply walked to and from work. The MEDDAC's Information Management Division, in coordination with the Directorate of

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Information Management, had class C (on-post only) telephones installed in physicians' rooms to facilitate their on-call requirements.

The MEDDAC's physician staff increased significantly with the arrival of the 3271st USAR Hospital. The integration of reserve physicians brought with it a host of management challenges which are discussed in the next chapter.

Throughout the post-deployment period, the MEDDAC received physicians cross-leveled from other reserve units. With the arrival of these physicians, the MEDDAC's physician staffing gradually crept upward. As it did so, the MEDDAC began releasing active-duty backfill physicians. Many of these physicians returned to their home stations just in time to join medical units deploying to Southwest Asia.

Managing the nursing staff presented a challenge quite different from the physician staffing problem. While the MEDDAC gave up most of its physician staff to the Division, it lost only three nurses. The remaining nursing staff was more than sufficient to handle the reduced inpatient workload, clinic workload, and SRP requirements. However, additional nurses were en route. The MEDDAC received a number of nurses who

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returned to active duty under the Army's volunteer program. It also received the nursing staff of the 3271st Hospital and later, a number of nurses cross-leveled from other units. Ultimately, the MEDDAC's nursing staff approached 200 percent of requirements, while its workload never reached the predeployment level.

Fortunately, the MEDDAC did not receive the casualties this generous nursing staff was meant to support. However, now it faced the unusual task for a hospital of managing an excess of nurses. Nurses were put to work on a variety of tasks. Obviously, most wards and clinics were staffed at or above requirements. Many nurses were involved in supporting the on-going SRP for mobilizing units. A vigorous cross-training program was initiated to ensure an adequate supply of nurses trained in general medical/surgical nursing. A number of nurses were assigned to special projects such as writing protocols, preparing and updating expansion plans, and working on certification programs. All in all, the MEDDAC derived significant benefit from its beefed-up nursing staff. Inevitably, however, the skills of many nurses were put to less than optimal use.

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Meeting the mission. The final management challenge facing MEDDAC leaders was to successfully meet the MEDDAC's new four-part mission. The MEDDAC's ability to meet its mission imperatives would truly determine its success.

The MEDDAC's mission, as delineated by the HSC Commander, was to: a) Staff deploying units at 100 percent with "trained and ready AMEDD personnel," b) support family members left behind, c) meet all requests from deploying units for medical supplies, and d) prepare to provide care for casualties returning from overseas. Support of family members is listed in priority number one alongside "staff deploying units." It is described as "of almost equal importance" to staffing deploying units. The HSC Commander gives further emphasis to the importance of caring for family members noting; "Even the perception of indifference or insensitivity in health care support will have a devastating effect on morale. We cannot allow this to happen." (Major, August 11, 1990).

The MEDDAC met its first priority. However, based upon interviews with deploying physicians, it would be wrong to consider them "trained and ready." Little was done prior to the deployment to improve the training or

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readiness of PROFIS physicians because of the mandate to continue family member care and the slow relief from HSC with backfill physicians.

Although the MEDDAC continued to provide family member care, it sent a strong message to the contrary by cancelling this service shortly after the alert. The MEDDAC quickly corrected its position on family member care and announced that care would remain available. Many of the local beneficiaries were unconvinced. For some, uncertainty of access to care was a factor in their decisions to leave the area (R. Norton, personal communication, September 10, 1990).

As the operation progressed and the MEDDAC's physician staff reached and then exceeded its predeployment level, care became more available. The MEDDAC Commander discussed the hospital's increasing capacity in videotapes for the installation's closed-circuit television station. The MEDDAC's capacity to provide care was discussed at the monthly Health Care Consumers' Committee meeting. The MEDDAC did not initiate a marketing effort to draw local beneficiaries into the facility, however. The MEDDAC

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might have provided care to more beneficiaries, and consequently reduced CHAMPUS costs, had it instituted such a program.

The medical logistics support the MEDDAC provided to deploying units was a highlight of the MEDDAC's support of Operation Desert Shield. The MEDDAC readily filled or forwarded all requests for medical supplies from deploying units. Logistics Division helped deploying units clarify their medical supply requirements. Materiel Branch developed a standard issue list for units without assigned medical personnel. Medical logistics support consistently exceeded the expectations of supported units.

The quality of the medical logistics support provided to deploying units may be attributable, in part, to the experience of the military personnel assigned to Logistics Division. The Chief of Logistics Division has had a number of assignments to divisional units, serving in various capacities. The Chief of Materiel Branch, likewise, has extensive experience in divisional units including command of a medical company in the 24th Division immediately prior to assuming his

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current position. All of the noncommissioned officers assigned to Logistics Division have experience in field units.

Due to their extensive experience, the military staff of Logistics Division could envision requirements, anticipate problems, and empathize with members of deploying units. It would be difficult to over-estimate the value of this experience in the MEDDAC's support of deploying units. Conflicts between Logistics Division and supported units were practically nonexistent because the Logistics staff understood what their counterparts in deploying units were undergoing. The performance of Logistics Division reinforces the wisdom of assigning AMEDD soldiers to field units during the early stages of their careers.

The MEDDAC's preparations to receive casualties took the form of contingency planning and training. The MEDDAC refined its expansion plans and considered a number of expansion scenarios. It planned for patient transportation and for liaison between other military and civilian facilities and the MEDDAC. Training ranged from operation and loading of ambulance buses to Advanced Trauma Life Support to nursing casualty preparedness. The MEDDAC was much better prepared to

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receive returning casualties as a result of these preparations.

In the researcher's opinion, the MEDDAC met its mission. Its performance was not flawless. The MEDDAC neglected to market its capabilities to the local community and failed to adequately assure the local beneficiary population that it would have continued access to care. However, on the whole, the MEDDAC performed its mission exceptionally well. It provided outstanding support to deploying units and thoroughly prepared for the receipt of casualties. In these respects, its performance was reported to have been markedly better than that of other similarly effected MEDDACS (B. Ramcharan, personal communication, 26 March 1991). The issue of the MEDDAC's mission performance will be addressed in a more objective fashion in a subsequent chapter.

VII. Reserve Mobilization Phase

The Reserve Mobilization Phase was not a "phase" in the same sense as the Predeployment and Post-deployment Support Phases. It is not a time-bound period. Reserve mobilization and preparations for reserve mobilization occurred throughout much of the operation. It is presented here as a distinct phase of the operation simply because it was the most noteworthy single event which occurred in the MEDDAC during Operation Desert Shield. As such, it deserves the special attention which this manner of presentation affords.

Preparations for Mobilization

The MEDDAC began preparing for the mobilization of the Army Reserve shortly after the onset of Operation Desert Shield. The Commander began "unofficially" alerting the staff to the pending mobilization on August 11, 1990. Initially, the staff expected a Presidential call-up of 200,000 troops and made its plans on this basis.

The MEDDAC's first concern was to prepare to receive and integrate the mobilized reservists destined to join the MEDDAC staff. It was anticipated that any call-up would include the 3271st USAR Hospital, the

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MEDDAC's designated augmentation unit from Charleston, South Carolina. A meeting was held on August 13th to begin planning for this units arrival. Billeting, transportation, in-processing, credentialing and other subjects were discussed during the meeting.

By the 16th of August, plans to receive MEDDAC augmentees were nearing completion and the MEDDAC staff began to shift its focus to supporting the mobilization of 13,000 reservists expected at Fort Stewart and Camp Blanding, Florida. The Commander directed the staff to "get its stuff ready" and be prepared to support the mobilization (C.H. Hood, personal communication, August 17, 1990).

The MEDDAC's mobilization planner was the central figure in all mobilization planning efforts. He had authored the MEDDAC's mobilization plan and had established close liaison with both installation and Forces Command (FORSCOM) mobilization planners. He was now due to leave Fort Stewart. With the announcement of the pending mobilization, he requested an extension to stay at Fort Stewart. Ironically, the request for extension was denied and the mobilization planner left the MEDDAC just as its mobilization plans were being effected.

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The MEDDAC staff knew the 3271st USAR Hospital, which did its annual training (AT) at the MEDDAC every summer. The staff was confident in the abilities of the personnel assigned to the 3271st and expected they would perform well upon mobilization. However, the staff was less sure of the qualifications of other members of the Army Reserve. A visiting Army Reserve medical unit commander did little to bolster confidence when he addressed the staff at morning report, saying:

Ya'll got to understand about some of our people. We've got one doctor who hasn't practiced medicine for 12 years. But he's the director of ambulance services for the state of Alabama. I have no doubt he's a good doctor. He's a good 100 pounds overweight, but he wants to help and there's something he can do. Ya'll might just have to help him out a little. (McGehee, personal communication, August 21, 1990).

Fortunately, the physicians which subsequently joined the MEDDAC staff were significantly better qualified, both physically and professionally, than the one described above.

The MEDDAC had made significant progress in its plans to support the mobilization when the call-up

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actually came. The initial call-up order was for only 40,000 troops and, to the MEDDAC's great surprise, the 3271st USAR Hospital was not on the list of units to be activated. The MEDDAC's plans to continue support to mobilizing units relied heavily on the additional personnel it would get from the 3271st. The mobilization planner (who had not yet departed) went to work on the problem. With a few phone calls, he rectified the situation and the 3271st was back on the list.

With the call-up now official, the MEDDAC began getting hard figures with which to work. Approximately 4,000 troops would be activated at Fort Stewart. These soldiers would arrive with their units during a ten-day window beginning in late August. They would require complete Soldier Readiness Processing and would do as much training as possible on-post prior to their deployment.

Pending mobilization of the 48th Brigade was rumored. The rumors, which proved partially accurate, held that the 48th would be activated at Fort Stewart and would then depart for the National Training Center in California. After 100 days of training, the unit would deploy to Southwest Asia and join the 24th

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Division. Whatever the scenario, it was clear the activation and processing of this 5,000 man unit would require considerable effort.

The Commander of the 3271st Hospital called the MEDDAC Commander on August 26th indicating he had received oral notification of his unit's alert. The oral orders were to bring only the unit's professional staff. Subsequent directives called for activation of physicians, nurses, and medically-oriented paraprofessionals. Few administrative personnel were activated with the unit. Among those not activated were the unit's cooks, whom the MEDDAC desperately needed. Neither the MEDDAC nor the 3271st was able to get these people added to the activation roster.

Mobilization and Integration

The 3271st arrived at Fort Stewart on August 31st, 72 hours after being formally alerted. Plans to meet the unit at the Fort Stewart gates with a welcoming party fell victim to Murphy's Law. Unaware of the plans for a welcoming ceremony, unit members sped by the gate en route to the hospital.

Upon arrival, members of the 3271st were assigned their quarters. The 24th Division Commander had left instructions that maximum use be made of available

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quarters on-post prior to issuing statements of non-availability, which would allow reservists to take quarters off-post. Consequently, those who were unhappy with their new quarters were told they did not have the option of drawing an allowance to take quarters off-post. Of all the decisions effecting the reservists during their stay at Fort Stewart, none more adversely impacted their morale than this one.

In-processing. The members of the 3271st were in-processed on the afternoon and evening of August 31st. Each unit member received a letter from the HSC Commander welcoming them as "full partners in an effort that the Commander-in-Chief has found vital to our national interests" (Major, August 31, 1990). After in-processing, the 3271st was given the long weekend off-duty. Most unit members chose to take this opportunity to return home to South Carolina and tie-up the loose ends many had left behind.

Integration. The 3271st USAR Hospital officially lost its unit designation and became part of the MEDDAC on September 4, 1990. An integration ceremony was held on the MEDDAC lawn to commemorate the occasion. The Army Surgeon General and the Chief of the Army Nurse Corps were in attendance. The Surgeon General

addressed the group, complementing the performance of both active and reserve members. After the Surgeon General's address, the MEDDAC Commander gave the order to "integrate the command." The two-unit formation of soldiers then turned, facing one another, and marched together, halting when they had intermixed. The two units had become one.

Orientation. The orientation of the 3271st began after the integration ceremony. Physicians attended a half-day clinical orientation seminar. This session, coordinated by the DCCS and CSD, featured presentations on general MEDDAC policies; quality assurance; medical records administration; the appointment system; the paging system; and capabilities and methods of interaction with radiology, the pharmacy, and the lab. The nurses from the 3271st were each assigned a sponsor from the Department of Nursing to help ease their transition into the active Army. The nurses attended a three-day orientation presented by Nursing Education and Staff Development (NESD). Enlisted members attended a similar orientation, also prepared by NESD.

Credentialing. Credentialing of the activated reserve physicians began upon their arrival. Each physician officially requested clinical privileges in

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his or her specialty. Thirty-day temporary privileges were granted while the credentials technician began assembling and verifying the necessary documents in the Practitioner Credentials File (PCF). Many physicians arrived without their PCF, state license, or any other documentation of their qualifications. Consequently, the credentials technician started almost from scratch, tracking down necessary documents, making primary source verifications, and requesting letters of recommendation from civilian hospitals and medical practices. Thanks to the diligence of the credentials technician, PCFs were completed and privileges awarded to all physicians before the expiration of the temporary privileges.

Physician capabilities. In many cases, physicians did not request and the Credentials Committee could not recommend full privileges. A number of activated physicians were incapable of performing all of the requirements of their positions. One physician, activated as a general surgeon, was actually a urologist who had been slotted as a surgeon. Four of the five activated internal medicine physicians had not done inpatient work for over ten years. Two of the four activated obstetrician/gynecologists had done no

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obstetrics for over ten years. One of the activated pediatricians had specialized in hematology/oncology and felt he could not adequately provide neonatal care. Another pediatrician had specialized in gastroenterology and had done no general pediatrics work for over ten years. (C. H. Hood, personal communication, September 7, 1990).

Limitations on the capabilities of activated reserve physicians could have potentially impaired the MEDDAC's ability to provide many customary services. While internal medicine is the backbone of the inpatient care system, 80 percent of the activated internists could not support inpatient care. Obstetrics is the MEDDAC's busiest service, yet 50 percent of the activated obstetricians could not provide obstetrics care. A busy obstetrics service generates a busy pediatric service. The pediatric services provided by the MEDDAC are primarily of a general nature. The MEDDAC has neither the specialists nor the equipment nor the trained ancillary staff to provide highly specialized pediatric services. Yet two of the activated pediatricians were highly trained subspecialists who could not provide general pediatric care.

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The MEDDAC Commander frequently contemplated discontinuing or reducing various MEDDAC services due to staffing problems. The staffing situation in internal medicine led him to anticipate discontinuing most inpatient care services (C. H. Hood, personal communication, September 19, 1990). Fortunately, the MEDDAC was able to overcome its staffing problems. It did this by keeping its active-duty backfill physicians for an extended period to supplement the activated reservists, cross-leveling subspecialists to medical centers in exchange for generalists, and by ultimately receiving additional activated reserve physicians. Through these measures, the MEDDAC was able to minimize service disruptions due to the staffing turbulence and imbalances.

The urology mission. The MEDDAC did not have a urology mission and could not use its activated urologist in the capacity of general surgeon, as he had been slotted. Attempts to cross-level this officer to a medical center were unsuccessful, and consequently the MEDDAC requested that HSC amend the MEDDAC's mission to include urology services. Without waiting for HSC's approval, the MEDDAC took advantage of an opportunity to purchase requisite urology equipment

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with year-end funds. While the contract for this equipment was being hurriedly negotiated, HSC's response came back disapproving the request. The Chief of RMD contacted HSC, explained the situation, and discussed the CHAMPUS cost savings which the urologist would generate. Health Services Command subsequently rescinded its disapproval and added urology to the MEDDAC's mission template as a modified mission area. Interestingly, the MEDDAC discovered a significant need for urology services and began pursuing a urology partnership which it hopes to effect upon the departure of the activated urologist.

A plan to improve the USAR. The Deputy Commander for Administration at the MEDDAC came up with a plan to better ensure reserve physicians meet the needs of the service. His plan would convert USAR hospitals into hospital units. Physicians from each hospital unit would be designated to fill a specific slot in a MEDDAC, medical center, or field hospital upon activation. Prospective USAR physicians would be credentialed by an Army MEDDAC prior to completion of the recruiting process. The MEDDAC would evaluate the physician's credentials in light of the duties his or her slot would require. Subspecialists would be

credentialed by a medical center. This plan, or a modification of it, could eliminate many problems such as those experienced by the MEDDAC during the reserve activation. (J. B. Freeman, personal communication, September 12, 1990).

Physician productivity. The Chief of RMD was particularly interested in tracking the productivity of the reserve physicians. He anticipated their productivity might exceed that generated by the active-duty physicians due to what he felt would be a civilian "pay-per-visit" orientation. The Chief of RMD was partly correct; surgical productivity increased. The increase was generally small with the exception of same-day surgery where the increase in output was significant. Productivity in the medicine services decreased rather markedly.

There are a number of possible explanations for the observed changes in clinical productivity. First, it is possible that surgical productivity increased, as suggested, due to a different orientation held by civilian/reserve physicians. It is also possible that the increased productivity was attributable to increased ancillary staff in the operating room. Most likely, the answer is a combination of these factors

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and others which were not identified. The decline in productivity in the medicine services might simply reflect a drop in the demand for these services. However, since appointment schedules remained full and waiting lists did not go away, any drop in demand should not have resulted in lower productivity.

The billeting problem. Billeting for activated reservists was becoming a major issue of contention between the MEDDAC Commander and installation officials. Activated reservists had been moved from the National Guard buildings into billets vacated by deploying soldiers of the 24th Division. Most of the senior officers were given quarters in the Bachelors Officers Quarters (BOQ). Other officers (generally majors and below) were moved into a vacated barracks which was declared a BOQ for activated reservists. In this building, majors were given private rooms. Captains and lieutenants were billeted two to a room. Officers quarters were substandard across the board.

The MEDDAC Commander requested an exception to policy to allow his activated reservists to draw a quarters allowance (known as basic allowance for quarters or BAQ) and take quarters off-post. The Installation Commander refused to allow an exception.

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This, in spite of the fact that HSC had indicated its willingness to pick-up the cost of the quarters allowance.

The MEDDAC Commander soon realized the billeting issue was a battle he would lose. He determined to do what he could to improve the lot of those confined to the "designated" quarters. This took the form of walk-through "health and welfare" type inspections by the MEDDAC Commander, DCA, Chief Nurse, Medical Company Commander, and Command Sergeant Major. After his first walk-through, the Commander noted the barracks were "dirty and poorly maintained" (C. H. Hood, personal communication, September 19, 1990). The buildings had apparently not been cleaned after the departure of the Division. The Commander identified senior occupants of each building and put them in charge of improving the living conditions. Personnel Division was given staff responsibility for monitoring and assisting the effort to fix-up the billets. Gradually, the situation improved. Dissatisfaction remained, however, due to the general inferiority of the quarters provided to our "full partners."

Medical screening. The SRP, ongoing at a reduced pace for remaining active-duty soldiers, now redoubled

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to support the reserve mobilizations. The process moved from the welcome center back into the gymnasiums as the mobilizing population increased. A greater incidence of medical problems requiring corrective action was noted among the reservists than had been the case for the active duty soldiers. Many of the deployment-limiting medical problems were the result of conditions which long predated the activation. This observation led the MEDDAC Commander to note, "the reserve components need to be a lot more particular about taking on board people who do not fit the mobilization and/or retention standards" (C. H. Hood, personal communication, October 15, 1990).

A good example of the kind of long-standing problems to which the MEDDAC Commander was referring occurred on November 14th. A soldier came in to the hospital for a deployability evaluation after having been screened-out of the SRP. He had had two myocardial infarctions and a cardiopulmonary-bypass graft. The soldier was at significantly increased risk for cardiac problems and should have been medically removed from the service long before. The soldier's unit was two days from deployment when his medical problems were discovered.

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Many of the activated reservists had deployment-limiting medical conditions which were potentially curable or correctable. The question arose of what to do with these soldiers. Should they be held and their problems repaired, or released from active duty? The MEDDAC Commander turned to the Staff Judge Advocate (SJA) for advice on this matter. After a bit of research, the SJA advised that the soldier should be released from active duty unless he or she can be brought to fully deployable status within 30 days. The MEDDAC Commander disagreed with this inflexible 30-day policy. He remarked:

....there is a clear distinction between a hernia repair followed by six weeks of convalescence, and a knee reconstruction which will still lead to a PEB [physical evaluation board] and, in all likelihood, as much as a year out. That is the issue the ARs [Army Regulations] don't seem to address very clearly (C. H. Hood, personal communication, October 18, 1990).

Visit by the DDEAMC Commander. The Commander of Dwight David Eisenhower Army Medical Center (DDEAMC), the regional medical center, visited the MEDDAC on October 24th. He met with activated physicians and

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observed afterwards that the MEDDAC Commander had tremendous leadership and clinical problems on his hands. The DDEAMC Commander also met with activated nurses and enlisted members where he encountered less hostility than had been the case with the physicians. In spite of the apparent morale problems with the physicians, the DDEAMC Commander noted that the MEDDAC was doing an outstanding job. He indicated the HSC Commander had expressed the same sentiment. (C. H. Hood, personal communication, October 24, 1990).

Continuing administrative problems. The October end-of-month payday proved that the transition of activated reservists was far from complete, at least in the financial sense. Many of the officers and enlisted members did not receive their BAQ. Many of the enlisted members had not received their mid-month pay. Further, some of the reservists who were not kept on active duty were not reentered into the USAR data base and could not be paid for their continuing USAR service. Some of these problems would persist until December and even beyond.

A situation discovered in January demonstrates that finance problems existed not only for reservists called to active duty but also for active duty soldiers

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who had left the USAR. On January 2nd, the MEDDAC Commander received a call from the wife of a deployed active-duty physician. She explained that her husband had not been paid since the end of October. As it turned out, the physician had previously belonged to a USAR medical detachment. He left that unit and re-entered the active Army in January 1990. The reserve medical detachment was called-up in November and, upon noting this physician's absence, reported him absent without leave (AWOL). The AWOL report somehow entered the finance system and stopped his active-duty pay. The situation was quickly rectified.

Extended Active-Duty Service

On November 19th, the MEDDAC received formal notice that activated reservists would be extended for an additional 90 days at the expiration of the initial 90-day call-up period. This was not unexpected and therefore did not upset many people. However, it did initiate a new round of speculation over what would happen at the end of 180 days.

The extension notice offered one caveat. The MEDDAC Commander was given authority to release

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activated reservists not essential to the MEDDAC's ability to accomplish its mission. Not surprisingly, the Commander chose not to exercise his new authority.

Many of the activated reservists, including most of the physicians, had already applied to HSC for release from active duty due to hardship. In most cases, these requests were made shortly after the activation. None of the applications sent by MEDDAC staff members were approved.

Information from Health Services Command. The previous Commander of the 3271st, now the MEDDAC's Deputy Commander for Mobilization and Reserve Affairs (DCMRA), attended an HSC Reserve Unit Commanders' Conference in December. Upon his return, he met with the activated reservists and attempted to clear the air of some of the earlier confusion and conflicting directives. He noted that in some cases FORSCOM had sent directives straight to the units and did not go through HSC. Frequently, HSC would then, unknowingly, issue conflicting directives. To correct this, all future directives to HSC units would come from HSC, thereby eliminating confusion.

The DCMRA explained the manner in which the medical mobilization unfolded. According to HSC

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mobilization plans, which are based upon a European war scenario, care to dependents in Army facilities would cease in the event of war. The Chief of Staff of the Army ordered HSC to continue dependent care during Operation Desert Shield. To staff deploying units and continue the provision of dependent care, HSC required the assistance of its reserve component members. Thus the initial call-up included many medical units. Due to the ceiling on the initial call-up, reserve medical units were not allowed to bring many of their administrative personnel. Unfortunately, mobilizing parts of units sent the incorrect message that some of the USAR soldiers are not important. Mobilization planners had become aware of this perception and later activations would call for mobilization of units in their entirety.

The DCMRA noted that the ceiling on the initial call-up had led to other problems. One such problem was the destruction of USAR hospitals for augmentation purposes. The 3271st is an augmentation hospital and, as such, expected to see its staff cross-leveled to other locations as necessary. However, the 3297th General Hospital is a mobilization hospital designed to be activated and operated as a unit. Like other USAR

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medical units, the 3297th was activated without many of its administrative and support staff members. Then, rather than operating as an independent hospital, the 3297th was broken-up and its staff used to augment facilities around the country. Staff members of the 3297th would ultimately be spread among 41 military treatment facilities. Its Commander, designated a brigadier general upon mobilization, was activated as a colonel and assigned as the DCMRA at Dwight David Eisenhower Army Medical Center.

The DCMRA concluded his discussion on an upbeat note. He congratulated the activated reservists for a job well done. He reminded them that their work was vitally important saying, "what you're doing here, though not highly visible, is very important; don't think that it's not." (B. A. Dantzler, personal communication, December 19, 1990).

Demobilization planning. In early January, while the situation in the Persian Gulf continued to heat up, the MEDDAC began finalizing its plans for demobilization. The MEDDAC Commander expected that all those soldiers who mobilized from Fort Stewart would

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demobilize at Fort Stewart. This meant the MEDDAC would need to process 35,000 soldiers, perhaps very quickly.

The plan for demobilization, written by the MEDDAC Commander, called for a demobilization process much like the SRP. Soldiers would enter a gymnasium in platoon-sized units; take seats in the bleachers; and receive briefings on medical benefits, long-term effects of endemic diseases, and general health issues. They would then proceed in single file through a series of medical stations including: Record screening; lab tests (as clinically indicated); vital signs; optometry; audiology; head and neck; chest; abdomen; extremities; rectal; pelvic exam; x-ray (if needed, possibly supported by field x-ray unit operated in the gym); and doctors final clearance. Specialty care requirements would be handled at the MEDDAC.

The demobilization plan would require extensive physician support. The Commander was concerned that the activated reservists could be released from active duty prior to completion of demobilization processing, thus greatly increasing the difficulty of the demobilization task. The Commander raised this issue with HSC, reminding them that the MEDDAC now depended

upon its activated reservists not only for current operations but would also need them to help support demobilization. The assistance of Army Reserve medical personnel would be necessary long after the cessation of hostilities.

The Reservists' Perspective

The activated reservists had varying perspectives of the call-up. Each individual has unique views shaped by his or her own experiences. This diversity became evident during discussions the researcher had with many of activated reservists. Summaries of several of these discussions follow.

Commander of the 3271st USAR Hospital. The Commander of the 3271st USAR Hospital discussed his personal experiences during the call-up and offered some interesting observations of the military health care system. A pediatrician by specialty and an allergist by subspecialty, he worked as a solo practitioner prior to the call-up. Speaking from personal experience, he notes that solo practitioners suffered the greatest financial hardship due to the mobilization. Physicians who were members of medical groups were, in most cases, able to keep their practices alive by shifting patients to their partners

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and going home to work on weekends. He tried this for a couple of weekends but felt it was unfair to his patients because he could not offer continuity of care. Therefore, he closed his office and is suffering the financial consequences.

The 3271st received a 72-hour notice to wrap-up personal details, assemble, and depart for Fort Stewart. This meant closing practices, getting powers of attorneys, and taking care of a multitude of other personal matters. Although this was a severe hardship on those being activated, the soldiers most upset over the situation were those being left behind. The unit was activated at approximately 90 percent strength. Many of the administrative and support staff members were not activated. These soldiers felt they had been told loud and clear, "you're not important." The Commander of the 3271st felt the decision to call-up less than the full unit was a mistake.

The mobilization taught the Army Reserve a lesson regarding physician staffing. According to the Commander of the 3271st, USAR hospitals have a problem with "super-specialists." They need to be more precise

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in assessing practitioner capabilities. It is imperative that physicians identified with a given slot be able to fulfill the requirements of that position.

The Commander of the 3271st found the "One Army" concept to be a rather hollow slogan. When the USAR soldiers entered the active structure, they found that the active-duty administrative computer systems were incompatible with those of the Army Reserve. Consequently, many of the finance and personnel records of reservists had to be recreated. The Commander also noted that while reservists are expected to be familiar with the active structure, active-duty personnel are not familiar with the reserve system. He cited billeting, the Officer's Club, and finance as areas in which the reservists were treated as less than equals. As an example, according to Army Regulations a full colonel is entitled to a minimum of 400 square feet of billeting space, yet the Commander of the 3271st had barely one-third of this.

The Commander of the 3271st noted that, although the quality of care provided in the military probably equals that available in the civilian sector, the military healthcare system is unnecessarily cumbersome and inefficient. He indicated that in civilian

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practice he has four support people who assist him in his office; at the MEDDAC the situation is more like four physicians to each support person. He noted that procedural issues like lab slips and other paperwork slow the physician down. These things do not require a physician's attention and could be easily handled by an assistant. He estimated that the MEDDAC gets no more than 50 percent of "physician" work out of its physicians with the rest of the time occupied in meetings, administration, and paperwork. The Army should aim to get 100 percent of "physician" work out of its physicians. This theme was repeated by many of the other reserve physicians with whom the researcher spoke.

The Commander of the 3271st did not emphasize the negative aspects of the mobilization. He wanted to point out those areas which he felt needed improvement and highlight serious problems, but did so in a constructive manner. The researcher has chosen to record the criticisms for their value to any future review of the mobilization.

A senior staff physician. The second summary is of a discussion with a senior physician assigned to the

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MEDDAC from the 3297th USAR Hospital. His experience differed significantly from that described above.

The 3297th USAR Hospital was alerted on August 26th and reported to Atlanta, Georgia on August 28th. This physician had returned on August 25th from two weeks annual training in Europe. He is a retired Veterans' Affairs physician who now works part-time as a consultant. Responding to the mobilization order simply required him to repack the bags he had brought home from Europe and drive to Atlanta. It did not create a great hardship for him.

The 3297th spent a couple of days going through a rather disorganized in-processing system in Atlanta. Then the unit moved to Fort Gordon where much of the Atlanta experience was repeated. After in-processing at Fort Gordon, the members of the 3297th learned they would be farmed out to hospitals and medical units around the country. This was quite a shock since the soldiers had expected to operate as a unit. Later, during an HSC site visit, it was learned that HSC had intended to break-up this unit all along.

The physician came to Fort Stewart in September. He noted that there was a billeting problem and, although not personally bothered by it, he felt it was

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a major irritant to many. He perceived support from the MEDDAC as good and believed the quality of care provided was equal to that available outside of the military. He did not note significant variations in the practice styles of military physicians from their civilian counterparts.

A nurse from the 3271st. A nurse from the 3271st said she anticipated the call-up when she heard the 24th Division was deploying to Saudi Arabia. She received a call from her unit on August 24th to verify her phone number. She was then alerted the next day but the alert was later cancelled. She did not hear anything further until she arrived at work on the 27th and was told the unit had been calling for her. She reported to the USAR center on the 28th where she spent the day helping plan the move. The unit was given the next two days off to take care of personal matters (for many this meant finding child care). On August 31st, the unit left Charleston en route to Fort Stewart.

The in-processing system at the MEDDAC was not well organized. The nurse noted that several colonels stood in line behind privates. Many members of the

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unit missed supper due to in-processing which began around four o'clock in the afternoon and ended around eight that evening.

After a long weekend, on which most unit members returned to Charleston, the in-processing continued on Tuesday, September 4th. The nursing orientation was held over the next three days and the nursing staff reported to their new duty stations on the following Monday, September 10th.

The nurse noted that the days preceding the mobilization and those immediately following it were frenzied. After awhile though, things began to settle down and the activated reservists began to feel more at home. However, due to the uncertainty, they could never feel truly comfortable with their situation. The initial call-up order was for a period of 90 days, then it was extended for 90 days, then for another 180 days. The activated reservists were unable to envision a date on which they could expect to return home. They were "living in limbo" throughout their stay on Fort Stewart.

The nurses too were upset over the housing issue. They felt the installation should have issued non-availability statements at the onset rather than

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forcing the activated reservists to live in substandard quarters. Ultimately, the activated reservists were given non-availability statements and told to move off-post to make room for the returning soldiers. Receiving non-availability statements upon arrival would have been welcomed; receiving them in this manner simply added insult to injury.

In spite of the problems, the nurse felt the mobilization was a very positive experience for many, especially those not familiar with the active military. She felt that the activated reservists learned a lot but contributed quite a bit also. Many of the reserve nurses and physicians have unique skills which they shared with the active staff during in-services and on-the-job-training.

The nurse observed that the MEDDAC is a wonderful facility but one which is under utilized. She feels the MEDDAC should add a cardiologist and keep some of its MIs (patients with myocardial infarction). She added that patients should be brought back to the MEDDAC following an acute phase in the regional medical center. She was very disappointed with the appointment system and thought it should be revamped. She experienced the frustration of calling repeatedly only

to get through and be told "there are no appointments available, call back next week." In her opinion, it is their inability to get an appointment that leads patients to make inappropriate use of the emergency room.

The nurse offered some final remarks regarding the long-term impact of the mobilization upon the Army Reserve. She indicated that, although her civilian employer would welcome her back, it would not be in the job she had held previously. As is the case with many others, her job has been filled by someone else and she will have to assume a new job. She enjoyed her previous job and is unhappy to have lost it. She expects the employment-related trauma on both employee and employer might have an adverse effect on the Army Reserve. "Will people still want to join the reserves, knowing it could cost them their jobs," she asks. "And more importantly, will employers still be willing to hire reservists? If everything else is equal, will the employer chose a reservist to whom he is obligated to give time off for annual training and who he might lose to a mobilization, or will he choose the non-reservist with whom there are no such difficulties?"

SECTION 3: Findings and Implications

In the remaining chapters of this study the results of the data collection and analysis are presented, potential implications are discussed, and conclusions are offered. The results of the formal data collection phase of the study are presented and analyzed in Chapter VIII. In chapter IX, Kotter's Model of Organizational Dynamics is used to frame the events which have transpired in the MEDDAC during Operation Desert Shield and to project their potential moderate and long-term consequences. Data gathered through both formal and informal means are used in presenting the model. Finally, conclusions and recommendations are offered in chapter X.

VIII. Formal Data Collection and Analysis

A variety of formal and informal data collection methods have been used in this study. These methods were discussed at length in Chapter IV. The primary methods of formal data collection include structured interviewing and document analysis. Structured interviews were conducted with members of the command group, department and division chiefs, and a stratified random sample of MEDDAC staff members. The document review consisted of analyses of the minutes of various

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MEDDAC committee meetings including: the Executive Committee, Joint Staff, Administrative Chiefs, Quality Assurance, Enlisted Troop Action Council, and Junior Enlisted Troop Action Council. The results of structured interviews and document reviews are presented in this chapter.

Interview results are presented according to the logic of table 1, which groups questions according to the objective each is designed to meet. The objectives of each interview are: to get a general feeling for the organization, to identify organizational changes which are related to Operation Desert Shield, and to identify and evaluate adaptive characteristics. In the document review, issues and trends noted in committee minutes for the period preceding Desert Shield are compared and contrasted to those observed during the period of Desert Shield.

Administration of Survey A

Survey format A, at Appendix A, was administered to members of the MEDDAC command group. This group includes the Commander, Deputy Commander for Administration (DCA), Deputy Commander for Clinical Services (DCCS), and Command Sergeant Major (CSM). Private interviews were conducted with each subject in

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his own office. The researcher conducted these interviews during the period April 05-09, 1991.

Questions 1 and 16 of Interview Format A were designed to provide a general feeling of the organization and a picture of how the members of the command group perceive it. The Commander and DCA initially answered question 1 in terms of how they felt about their jobs. Each used terms such as "challenging," "rewarding," and "the best job around." In describing his job, the Commander noted that he was responsible for the health and welfare of his soldiers, for the correct prosecution of AMEDD policy, for the quality of care provided, and for supervision of military health services throughout much of Georgia, Florida, and South Carolina. Other members of the command group described their jobs in less global terms, identifying their primary area of responsibility. The DCA noted that his job entails supervision of the administrative aspects of the MEDDAC. The DCCS described his job as that of a "buffer between the Commander and clinical staff." The CSM sees his job as that of spokesman for the enlisted members of the MEDDAC staff.

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In response to question 16, all members of the command group agreed that the MEDDAC had performed its mission extremely well. They used the following phrases to describe the MEDDAC's performance: "Well ahead of the game in every aspect," "leader in HSC," "High marks, 95 to 98 percent effective," and "ahead of the others."

Questions 2 and 3 were designed to evaluate organizational changes which have come about in response to Operation Desert Shield. The Commander, DCA, and CSM all indicated their jobs did not change with the onset of Desert Shield. Each noted, however, that their methods had changed and that their efforts were much more "mission focused" than had been the case previously. Not surprisingly, the DCCS answered that his job had changed significantly during the six months of Desert Shield. Prior to his unit's activation, he worked as a civilian private practitioner. Upon activation, he became Chief of the Department of Medicine at the MEDDAC. Later, he moved up to the position of Deputy Commander for Mobilization and Reserve Affairs, and finally to DCCS.

In response to question 3, the members of the command group all noted changes which they attributed

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primarily to the tremendous personnel turnover which the MEDDAC experienced. They noted that operating with a new staff required tighter supervision from the command group. The Commander expressed this as "getting people to fall in with the right philosophy." The DCA cited increased demands on his time to "deal with the many aspects of the immediate mission." The CSM noted a number of problems and a decreased level of care because the MEDDAC was operating with "not as solid a core." The DCCS indicated the change was not so much in the way the MEDDAC does things, but rather in who does them. He felt the use of reservists demonstrated the MEDDAC's flexibility.

The Commander cited the opening of the ACES clinic, the closure of two other clinics, and the addition of several missions (TMC, port support, etc.) as structural changes which have occurred in the MEDDAC during the period of Desert Shield. The CSM noted the creation of new "semi-formal" positions of commander and first sergeant for the activated USAR staff members.

When asked if there had been any changes in the way he gets things done, the DCA replied that he had been forced to rely more on his subordinates since the

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onset of Desert Shield. The CSM said it had become much harder to do business with the installation staff since the division had gone. The Commander and DCCS noted no change in the way they get things done.

Questions 4-8 and 13-15 are designed to assess the quality of leadership in the MEDDAC. The most important question among these, and perhaps the most important of this interview format, is question 4 which asks the respondent to describe his leadership style. The Commander gave the most colorful answer, describing his leadership style as "Ghengus Khan--three steps to the right." He followed this with a more practical assessment using terms such as, "structured," "personal," "hands-on," "firm but flexible," and "predicated on the belief that everyone will respond if treated ethically and approached with integrity." The Commander also noted that he does not hesitate to solicit input from the experts on his staff.

The DCA expressed his leadership style as designed to "promote the growth of individuals." He indicated that he "is demanding but doesn't punish mistakes," "promotes innovation," and "rewards those who succeed and confronts those who fail." The DCCS said quite simply that his leadership style is "leadership by

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example." He cited the golden rule as his motto and said he does not ask others to do anything he would not do himself. The CSM described his leadership style in situational terms saying it ranged from participative, which he prefers, to authoritarian. He feels that troops respond positively and "grow" under participative leadership. But if "the information is not available" or he is "not getting what is needed," he takes a more authoritarian tack. All members of the command group noted no change in their leadership styles during Desert Shield.

In question 5, command group members were asked about their involvement in the daily operations of the MEDDAC. All members of the command group indicated they were intimately involved in the MEDDAC's daily operations. The Commander and DCA noted they had less time to "get out and around" the MEDDAC since Desert Shield. The DCCS felt he had become "more knowledgeable" and had gotten "a better handle on things" since the beginning of his period on active duty. The CSM expressed frustration at not being able to influence the careers of the activated USAR soldiers

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because such things as promotions and educational opportunities for them were controlled by the Department of the Army.

In question 6, the subjects were asked to describe their decision making process. The Commander delineated his decision making process as follows: "Identify the problem, study it to the extent necessary, understand the problem and its relation to other things, solicit expert input, hold meetings if necessary, enunciate a plan, and get on with it." The DCA indicated that he relied on "facts and the advice of the leadership around him and [the advice of] his chiefs" in making decisions. He added that he often relies on his "gut feeling supported by [his] 28 years of experience in the military health care environment." The DCCS noted his decision making process was very "methodical and organized." He "weighs the facts, looks at the pros and cons, and makes a decision." The CSM said he makes decisions by "looking at the problem, considering the impact of various options, and making a decision."

The members of the command group were asked in question 7 if they had relied more or less on input from their staffs since the onset of Desert Shield.

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This question was designed to provide an indication of both the type of leadership and the level of participation in the MEDDAC. The Commander answered that he had relied "considerably more" on his staff. The DCA and DCCS also indicated they had relied heavily on their staffs. The DCCS noted that he used staff members "almost like consultants because they are the experts in their areas." The CSM said he had relied less on his enlisted staff's input, especially early in the operation.

In question 8, the DCA, DCCS, and CSM were asked if they felt the Commander had relied more or less on their input since the onset of Desert Shield. This question was also designed to generate information on both leadership and participation in the MEDDAC. Once again, the DCA and DCCS were in agreement, both indicating the Commander had relied more heavily on them. The DCA noted that the magnitude of the Commander's job would have "consumed him if he had not turned to his deputies." The CSM felt the Commander had not relied upon him as heavily during Desert Shield because "most of the issues he was dealing with were not enlisted matters."

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The respondents were asked in question 13 to state the mission of the MEDDAC. The Commander said the MEDDAC's mission was:

To provide quality medical care in sufficient quantity to meet the needs of eligible beneficiaries; to maintain and improve the military medical training base; to support Fort Stewart, Hunter Army Airfield, and the 24th Division; to enhance the image of military medicine where possible; to explore new avenues for providing more care to more people, and; to enhance the growth of MEDDAC personnel.

The other members of the command group recited similar mission statements but in less detail. Their descriptions centered around providing care to eligible beneficiaries. The DCA noted the veterinary mission and "other missions." The CSM noted training, but added "we've never really had the resources to do both [train and provide care]."

In response to question 14, the command group members agreed the mission of the MEDDAC had not changed with the onset of Desert Shield. The DCA, DCCS, and CSM noted the additional requirements of supporting the deployment and preparing to receive

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casualties, but felt these did not constitute a change in mission.

In question 15, the respondents were asked how they measured the MEDDAC's effectiveness in meeting its mission. The Commander listed many "yardsticks" including: "the rate of complaints, various touchstones required by regulation and policy, JCAHO and other regulatory agency standards, and a number of vague things such as how responsive we are to patients' needs." He continued, indicating that he relies somewhat on his "feeling" as he walks around the MEDDAC, but is careful not to loose sight of the objective indicators. The DCA said he assesses the MEDDAC's performance based upon the compliments and complaints of "the installation leadership, community leaders, the average soldier, and the average dependent." He also depends upon his ability to "sense [the MEDDAC's performance] as he walks through the MEDDAC on a day-to-day basis." The DCCS and CSM both said they felt a good indicator of the MEDDAC's performance was its ability to continue to provide key services in difficult times.

Questions 9-12 were designed to provide insight to the quality of communication within the MEDDAC. The

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command group's unanimous assessment was that communication within the MEDDAC was not very good. The Commander expressed frustration at the difficulty of getting communication to flow upward. He observed that "people are reluctant to enunciate a problem until it gets real bad." The DCA noted that information did not seem to be getting down into the organization. He added that he believes "the headquarters has tried to put out good, timely, accurate information but there seems to be a lack of communication between department, service, and activity chiefs and their staffs."

In addition to providing insight to the status of communication within the MEDDAC, questions 10-12 seek to generate clues to the MEDDAC's receptiveness to new ideas or innovation. Questions 10 and 12 may also shed light on the degree of participation within the organization. In response to question 10, the Commander noted that communication seems to be "60/40 top-down." The DCA and CSM agreed that the communication flow is primarily top-down. The DCA added that communication flows "down to the activity chief level and then stops." The DCCS said that communication probably flows both ways equally. He noted, however, that he often feels communication in

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his area flows more from the bottom-up than from the top-down.

In question 11, the respondents were asked if communication in the MEDDAC had improved since the onset of Desert Shield. The Commander noted that communication had improved during Desert Shield but it was still not as good as it had been prior to the operation. The DCA indicated that communication might have improved slightly because staff members are making a greater effort to "listen up." The CSM felt that communication had gotten worse not only in the MEDDAC but across the post. He added that communication typically deteriorates during a crisis. The DCCS noted that communication had steadily improved as reservists became more familiar with the organization.

In question 12, command group members were asked if the staff felt comfortable making suggestions and, if so, if the suggestions were frequently acted upon. The Commander answered that he hoped the staff was comfortable making suggestions. He added that his close staff was "not the least bit reluctant in telling me when I'm doing something stupid, which is good." The DCA indicated that the staff should feel comfortable making suggestions, but he sees few

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proposed. The DCCS felt his staff was very comfortable making suggestions. The CSM cited statements made to him by MEDDAC soldiers which indicated they were not comfortable making suggestions. He said soldiers tell him the "second floor [headquarters] doesn't listen. They say we pay lip service, that we say we want input but we really don't."

The members of the command group agreed that all suggestions are considered and those with merit are implemented. The DCA added that he had recently initiated a program of asking attendees at the monthly Newcomers' Orientation for suggestions. Their suggestions are given to the Commander who circulates them to the staff for evaluation. The CSM noted that the command group was much more receptive to suggestions than the staff realized.

Analysis. Based upon their responses to questions 1 and 16, it appears the members of the command group enjoy their jobs and are well satisfied with the performance of the MEDDAC. It is interesting to note, however, that while the Commander describes his job in terms of organization-wide responsibilities, as might be expected, the other members of the command group appear to see their jobs in terms of specific aspects

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of the organization. The DCA noted his responsibility was for the administrative areas of the MEDDAC. The DCCS cited the clinical areas, while the CSM indicated he was the "spokesman for the enlisted members of the staff." This division of responsibility is not inappropriate and is, in fact, the way the command structure of the MEDDAC is designed. However, if the other members of the command group are not looking beyond the bounds of their respective areas of responsibility (administrative, clinical, and enlisted), this leaves the Commander as the only person looking at the entire organization. This indicates that leadership in the MEDDAC may be better described as "leadership by an individual" than as "leadership by a group."

The members of the command group generally indicated in response to question 2 that their jobs had not changed as a result of Desert Shield but that their efforts had become more "mission-focused." In response to question 3, the command group members cite changes which they attribute primarily to personnel turnover. The Commander, DCA, and CSM all note the requirement to

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tighten supervision. The Commander and CSM cited some rather minor structural changes. The DCA and CSM note some changes in the way they get things done.

The responses to questions 2 and 3 indicate that the MEDDAC did make some changes in its internal processes during Operation Desert Shield. As demonstrated in Kotter's Model of Short-term Dynamics (see Figure 1), changes in internal processes may be expected in response to changes in one or more of the six structural elements. The model also demonstrates that any changes in a structural element or in an organization's internal processes can effect other structural elements. The issue of organizational changes and the implications of Kotter's Model will be revisited in chapter IX.

Questions 4-15 represent an attempt to generate information with which to evaluate the MEDDAC's responsiveness to change. In chapter II, the case was made that organizational responsiveness to change is largely contingent upon the status of leadership, communication, innovation, and participation within the organization. Questions 4-15 are designed, as depicted in table 1, to help identify these adaptive characteristics.

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The responses to questions 4-8 and 13-15 support the notion that the leadership in the MEDDAC may be characterized primarily as leadership by an individual. In describing his leadership style, the Commander painted a picture of himself as something of a friendly authoritarian. Other members of the command group seemed to rely more upon participative leadership styles. All indicated they are intimately involved in the daily operations of the MEDDAC but that they depend upon input from their staffs. The Commander offered a well-defined decision-making process. Other members of the command group described processes which rely to a considerable degree on intuition. All members of the command group felt the Commander relied heavily upon them. However, the CSM noted the Commander's reliance on him had decreased since the onset of Desert Shield. The Commander offered the most comprehensive mission statement and cited a number of objective indicators with which to assess the MEDDAC's performance. Once again, other members of the command group seemed to rely more on intuitive means of assessing the MEDDAC's performance.

The command group depicted a situation of generally moderate to poor communication within the

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MEDDAC. While the Commander was frustrated at the inability to get communication to flow upwards, the DCA was frustrated that it didn't seem to flow downwards. The DCCS noted that in his area the communication flow is often bottom-up, but he "shields" the Commander from these daily problems. The CSM noted that soldiers do not believe the headquarters really wants to listen to them.

The members of the command group expressed a receptive attitude toward new ideas. With the exception of the CSM, they agreed that the staff is comfortable in making suggestions. However, they note that suggestions and innovations do not occur frequently. It is possible that the information flow, which they generally agreed goes top-down, inhibits innovation and creates what the CSM described as a perception that the headquarters only "pays lip service" to innovation.

Responses to the questions designed to generate information on the level of participation within the MEDDAC did not yield a clear picture. The command group generally agreed that they rely on input from their subordinates. The Commander noted that his "close staff" readily tells him when he's making a

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mistake. Other members of the command group indicate they are receptive to new ideas from subordinates but do not get them often. Once again, the downward flow of communication could inhibit participation.

Interestingly, the Commander described his leadership style in authoritarian terms, yet the decision-making process he depicted exhibits participative characteristics. This is a contrast to the other members of the command group who describe participative leadership styles, while offering seemingly authoritarian decision-making processes.

Summary. Based upon the results of Interview Format A, the MEDDAC appears to have performed its mission exceptionally well during a short-term crisis situation. Doing so, required that the MEDDAC make some changes in its internal processes in response to changes in its environment. The key leader of the MEDDAC is its Commander, who describes his leadership style in authoritarian terms but who exhibits participative tendencies. Communication in the MEDDAC is moderate to poor and flows primarily top-down. MEDDAC leaders articulate a desire to spur innovation

and participation but neither innovation nor participation seem to exist at the level the leaders desire.

Administration of Survey B

Survey format B, at Appendix B, was administered to administrative division chiefs and clinical department chiefs. On the administrative side, this group includes the chiefs of: Information Management Division; Resource Management Division; Logistics Division; Patient Administration Division; Nutrition Care Division; Plans, Training, Mobilization, and Security Division; and Personnel Division. On the clinical side, the group includes the chiefs of: the departments of Medicine, Surgery, Primary Care and Community Medicine, Nursing, and Ministry and Pastoral Care, Pharmacy Service, Clinical Support Division, and the Quality Assurance Office. Interviews were conducted during March and April 1991. The chiefs of the departments of Medicine, Primary Care and Community Medicine, and Ministry and Pastoral Care were not interviewed.

Questions 1 and 17 were designed to provide a general feel for the organization as it is perceived by the respondents. In question one, respondents were

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asked to describe their jobs. Those from the administrative side used the terms manager, director and facilitator, to describe their jobs, while those from the clinical side chose planner, coordinator, and administrator. Over half of all respondents to question 17 indicated the MEDDAC had performed its mission very effectively and all rated the MEDDAC's performance as at least fairly effective.

Questions 2 and 3 were designed to determine whether changes had occurred in the MEDDAC since the onset of Operation Desert Shield. The overwhelming majority of respondents indicated changes had occurred. The most commonly cited change was increased work load, particularly among administrative participants. Clinical respondents noted increased "administrative chores" and more "fire fighting." In response to question 3, three of the administrative respondents and all five clinical respondents indicated Desert Shield had changed the way their offices did business. However, less than half of the respondents indicated their department or division had made any structural changes and only two respondents said they had changed the way they get things done.

Questions 4-8 and 14-16 were designed to generate information about the leadership of the MEDDAC. In response to question 4, participants used a variety of nouns and adjectives to describe the Commander's leadership style. The most frequently used term was "micromanager," cited seven times. Other words and phrases offered as descriptions of the Commander's leadership style include: "does too much," mentioned four times; "decisive" and "unilateral" each noted twice; and "involved," "authoritarian," and "threatening," each cited once. One respondent noted that the Commander "shoulders too much of the burden and doesn't let the staff do their thing." Another said:

He was the best man around for the situation we were in. He was reasonably inflexible about receiving recommendations from the staff. He had his own ideas and was usually right. [In such a situation, you] need a man who is strong, capable, forceful, and willing to take on his shoulders whatever is necessary to get the job done.

(Anonymous, April 25, 1991).

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There was almost unanimous agreement that the Commander's leadership style had become more directive since the onset of Operation Desert Shield.

Question 5 was designed to provide insight into both the leadership and degree of participation within the MEDDAC. Respondents to this question generally agreed that the Commander seemed to rely less on other members of the command group during Operation Desert Shield than he had prior to the operation.

In question 6, participants are asked how involved the Commander is in the daily operations of the MEDDAC. The majority indicated he was "very involved." Two respondents indicated he was fairly involved and two indicated he was not involved in the MEDDAC's daily operations. One respondent from the majority indicated the Commander "is as deeply [involved] as is humanly possible [in all aspects of the organization]; from grass cutting to brain surgery, he will direct either as fully as he possibly can."

Like question 5, questions 7 and 8 were developed to generate information with which to assess both leadership and participation in the MEDDAC. Question 7 asks how involved other members of the command group are in the daily operations of the MEDDAC. Once again,

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the respondents indicated command group members are very involved. In response to question 8, six respondents said the command group had relied more on them since the onset of Desert Shield, while three felt the command group had relied upon them less and three noted no change.

Questions 9 and 10 were designed to help assess the quality of communication in the MEDDAC and the MEDDAC's receptiveness to innovation. In response to question 9, all five of the clinical participants indicated they felt comfortable suggesting new methods to the DCCS. Four of the administrative respondents said they felt comfortable approaching the DCA with suggestions and three said they did not. Four of the respondents on the clinical side felt their suggestions to the DCCS would be acted upon and one did not. On the administrative side, four thought their suggestions would generate action, while three felt nothing would happen as a result of their suggestions.

In response to question 10, participants generally expressed reluctance to criticize decisions made by their superiors. However, six felt if they did criticize a decision, the Commander or command group would reconsider the decision. In contrast to their

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initial response, the vast majority of respondents (10 of 12) indicated they had gone to the Commander or a member of the command group and criticized a decision. All of the clinical respondents said they had criticized decisions and three noted the decisions had been changed as a result of their criticism. Five of the seven administrative respondents said they had criticized decisions, but all five indicated the decisions had not been changed as a result of their criticism.

In question 11, survey participants were asked how good communications are in the MEDDAC. The consensus opinion, cited by seven of twelve, was that MEDDAC communications are fair. Two respondents felt communications were good and three said communications were bad. In response to question 12, which was designed to generate information about both the status of communication and the degree of participation in the MEDDAC, most respondents (8 of 12) felt communication flowed from the top-down. None of the respondents said communication flowed from the bottom-up, but four thought the flow was equal in both directions. Responding to question 13, four participants thought communications had improved during Desert Shield, four

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thought communications had deteriorated and four noted no change.

In question 14, respondents were asked to state the MEDDAC's mission. The purpose here was to determine how effective MEDDAC leaders have been in communicating a clear, uniform understanding of the MEDDAC's mission. Six respondents said the mission was "to provide medical care to active duty soldiers, their family members, and retired military beneficiaries in the Fort Stewart area." Other responses, cite twice each, include: "provide health care to eligible beneficiaries," "provide patient care," and "provide the best care possible." One respondent added that the MEDDAC also has the mission of providing medical training to its staff members.

Question 15 was developed to assess the ability of the administrative and clinical chiefs to relate the MEDDAC's mission to their functional area. Three clinical respondents and two administrative respondents did so using specific terms, reflecting a detailed understanding of their role in the organization. Two from the clinical side and five from the administrative side used general terms, possibly indicating a less secure grasp of their purpose in the organization.

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In question 16, respondents were asked if the mission had changed with the onset of Operation Desert Shield. Responses to this question were anticipated to reflect upon the leadership, communication, and participation extant within the MEDDAC. The majority of the respondents (9 of 12) indicated the mission had changed. These respondents noted unanimously that the mission had become much more focused upon "readiness" and "supporting the active duty soldier." Three respondents felt the mission had not changed.

Analysis. The respondents to this survey appear to view themselves appropriately as the middle to senior-level staff of the MEDDAC. This is evidenced by their responses to question one, in which they use terms such as "manager," "planner," and "director" to describe their jobs. They clearly do not view themselves as merely practitioners, but rather as staff members who have a degree of influence within the organization. The majority of the respondents feel satisfied that the MEDDAC has performed its mission very well.

The division and department chiefs indicated that changes have occurred in the MEDDAC since the onset of Desert Shield, but these changes seem rather minor in

nature. Increased work load was the most frequently cited change, indicating that most processes might have been left unchanged. The mention of increased "fire fighting" could support this notion. It is likely that as the amount and type of work increased, problems occurred with existing processes requiring more supervisory attention. Some structural changes were made but most division and department chiefs continued to do things the same way. This suggests that while some processes were changed, the more common rule was to simply rely on the extant processes to get the job done.

Survey respondents clearly depict the Commander as an authoritarian leader. He was accused of being a "micromanager" and of doing too much, but was also cited as "the best man for the situation." His leadership style appears to have become more directive and controlling during Operation Desert Shield. The division and department chiefs felt he relied less upon other members of the command group during Desert Shield than he had prior to the operation. They note that he was very involved in the daily operations of the MEDDAC. The Commander's leadership style may be best summed up by a quote from one of the survey respondents

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who noted: "[The Commander] took the bull by the horns and said, 'make things happen.'"

The division and department chiefs depicted the other members of the command group as also being closely involved in the daily operation of the MEDDAC. They noted, however, that the other members of the command group seemed to rely a bit more on the staff's input than did the Commander.

Respondents from the clinical side expressed a willingness to approach the DCCS with suggestions and new ideas. They felt their suggestions would probably generate some action. Administrative respondents were less willing to approach the DCA with new ideas, although those who said they would make suggestions felt their suggestions would be acted upon.

The senior staff seems reluctant to criticize decisions made by the Commander or command group. Most of the respondents, however, have gone to the Commander or another member of the command group at some time to criticize a decision. All of the clinical respondents said they had criticized a decision and most saw the decision changed as a result of their criticism. On the administrative side, however, none of the respondents saw decisions changed as a result of their

criticism. This could explain the reluctance of the administrative staff to come forward with suggestions. Further, this suggests that the MEDDAC might not be as receptive to innovation or participation as members of the command group perceive.

The division and department chiefs rate communications within the MEDDAC as fair to poor. They note that communication seems to flow primarily from the top-down. They saw no change in the amount or direction of communication during Desert Shield.

The senior staff seems to have a fairly consistent understanding of the MEDDAC's mission, but are not exactly sure how their functional area fits into the picture. Many respondents were apparently unable to relate the MEDDAC's mission to any specific objectives for their functional areas. This finding implies that perhaps leadership, communication, and participation might all be improved.

The inability of division and department chiefs to cite a completely uniform mission and to list specific objectives for their functional areas suggests that perhaps the MEDDAC leadership has not clearly articulated an organizational mission statement. It also implies that responsibilities are not clearly

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delineated among the divisions and departments.

Communication and participation might be expected to improve if department and division responsibilities are clearly understood by all. Organizational performance might improve if all members understand the mission and the specific objectives of their functional areas.

While some misunderstandings might exist regarding the mission and objectives of the MEDDAC, the senior staff clearly noted a change in emphasis during Operation Desert Shield. They depict the MEDDAC as assuming more of a "readiness" orientation. Increased support to active duty soldiers and preparations for war-time expansion were noted as changes in the MEDDAC's mission during Desert Shield.

Administration of Survey C

Interview Format C was administered to a random sample of 30 MEDDAC staff members stratified by status (officer, enlisted, or civilian) and duty (clinical or administrative). The stratification is demonstrated in table two. Employees names were selected from Medical Expense Performance Reporting System (MEPRS) printouts. Separate printouts were obtained for officers, enlisted members and civilians. The printouts were produced on April 5, 1991 and contained only the names and duty

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sections of each employee. Employees were segregated based upon the duty section reported on the MEPRS printout into clinical and administrative groups. The names of five employees from each category (administrative officer, clinical civilian, etc.) were chosen with the use of random numbers. Two alternates were chosen from each category.

Insert Table 2 about here

The interviews were conducted during the period 09-12 April 1991. Interviews were conducted privately by the researcher in each respondent's work area. Two of the individuals to be interviewed were not available and one chose not to be interviewed. In these cases, alternates were interviewed.

Questions 1, 2, 7, and 8 were designed to generate general information about the staffs' perception of the MEDDAC. In response to question 1, the staff overwhelmingly indicated the MEDDAC is a good place to work. Twenty seven of those interviewed said the MEDDAC was a good place to work, two were not sure, and one said it was not a good place to work. When asked why the MEDDAC was a good place to work, 15 respondents

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cited the people they worked with as the primary reason and 12 cited the satisfaction they get from their job. One of the individuals who was unsure if the MEDDAC was a good place to work said she liked the people, the other indicated he liked his job. The person who said the MEDDAC was not a good place to work based this statement on his opinion that "decisions here are made in a vacuum without input from the staff."

When asked in question 2 how they like their jobs, twenty five of the respondents said they like it and five said it was okay. Of those in the "like it" category, 12 used the terms "love it" or "great" to describe the way they felt about their jobs. When asked what they most like about their jobs, 21 of the respondents cited one or more aspects of the job and nine stated they enjoyed helping people. As to what they most disliked, ten cited "lack of support," problems with "supervisors" or "senior staff," or "bureaucracy." Eight respondents said they most disliked one or more aspects of their job and eight others cited problems with working conditions. Two respondents cited personal problems and two could not think of anything they disliked about their jobs.

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The respondents were asked in question 7 how effectively the MEDDAC had performed its mission. By an almost unanimous consensus, the respondents indicated the MEDDAC had been at least moderately effective. Thirteen of the people interviewed said the MEDDAC had been very effective. Nine people responded that the MEDDAC had been effective and seven said it had been moderately effective. One person was unsure how well the MEDDAC had performed its mission.

The final question generated the greatest diversity of responses. In question 8, respondents are asked what one thing they would suggest to improve the MEDDAC. By an overwhelming margin, the staff indicated improving communication as the one thing which would improve the MEDDAC. Twelve people cited communication as the most needed improvement, the next most popular responses, "improve the appointment system," "increase command presence/improve leadership," and "increase staff/resources," were mentioned only three times each. The need to improve the MEDDAC's reputation in the community was mentioned by two respondents. Other responses, noted by one person each, include: "improve support," "increase parking," "improve screening of physicians," "return active duty staff," improve the

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courtesy of the MEDDAC staff," "don't know," and "improve working conditions."

The objective of question 3 was to provide information regarding changes which may have occurred in the MEDDAC since the onset of Desert Shield. In response to this question, Twenty six employees indicated they had noticed changes in their work areas, one said he had not noticed a change, and three were unsure. The descriptions of the changes varied widely. Many of the respondents listed several changes. Among the changes cited, twelve related directly to personnel turnover, thirteen involved changes in processes or the creation of new processes, twelve regarded increases in work load, and six involved changes in working conditions. Five of the respondents noted changes in the form of increased training, three cited improved morale or teamwork while three others cited decreased morale, two noted decreased work load.

Questions 4-6 were designed to provide information on the type and effectiveness of leadership in the MEDDAC. Responses to questions 4 and 6 may also be used to assess the effectiveness of communication in the MEDDAC. In question 4, respondents were asked if they felt they knew what was going on in the MEDDAC.

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Sixteen people answered that they did know what was going on, seven thought they knew "sometimes" what was going on, and seven said they did not know what was going on in the MEDDAC. The most frequently cited means of finding out what is going on was the supervisor, mentioned by 15 respondents. Other methods of getting information included: co-workers cited 12 times; the bulletin board, daily bulletin, or distribution cited 11 times; meetings cited 9 times, and; rumors or "the grapevine" also cited 9 times.

Question 5 was designed to provide information which may be useful in evaluating the effectiveness of leadership and the degree of innovation and participation in the MEDDAC. It asks what the respondent would do if he or she had a good idea. A majority of the respondents (13) answered they would take the idea to their supervisor. The next most popular response given by eight people was to go to the supervisor of the area impacted by the idea. Other answers included: the Army Suggestion Program, 3; nothing or don't know, 2; co-workers, 1; and command group (DCA), 1. The follow-up question asked respondents if they would expect to see some action taken on their idea. Thirteen respondents indicated

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they would expect to see action or at least see their idea receive consideration. They would expect to be notified of the decision to implement or not to implement the idea. Eleven people said they thought their idea might generate some action. Six employees felt nothing would result from their suggestion.

In question 6, respondents are asked to state the mission of the MEDDAC. The most popular responses, identified by 10 people each were "to provide medical care to all beneficiaries" and "to provide patient care." Other responses were "to care for soldiers and their families" identified by seven respondents, "to conserve the fighting strength" identified by two, and "first to care" mentioned by one person. The follow-up question asked the respondents to identify the objectives of their offices, wards, or clinics. The answers to this question were of interest not so much in their content but in the manner in which they were phrased. Some employees gave specific objectives such as "providing internal medicine services" or "admit patients, account for patients, and coordinate MEDEVAC flights." Others used general terms such as "provide patient care" or "support the people who treat the patients." Seventeen staff members chose to describe

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their unit's objectives in general terms, while thirteen gave specific descriptions.

Analysis. It is possible to draw a number of generalizations based upon the responses from Interview Format C. First, it is clear the staff considers the MEDDAC a good place to work. They attribute this largely to friendly, helpful co-workers and a pleasant work atmosphere. Most of the staff seem to enjoy their jobs often citing reasons such as "opportunities to learn," "ongoing training," and "control over [their] work." Employees dislike such things as a perceived "lack of support" from above and "bureaucracy." They also note irritating aspects of their jobs such as "phone calls" or "administration" and working conditions such as shift work. While noting a problem with communication, the staff feels the MEDDAC has performed its mission very effectively.

It appears that some changes have occurred in the MEDDAC during Operation Desert Shield. The staff notes new processes, perhaps driven by the large influx of new people. Respondents also noted increased work load created as the MEDDAC supported the deployment and reserve mobilization, and prepared for war.

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Staff members appear willing to approach their supervisor or the supervisor of another area with new ideas, suggesting that they are willing to participate in the organization. However, a large percentage of employees seem to doubt that any action would be taken to implement their ideas. This could indicate a leadership problem and suggests the MEDDAC may not be receptive to innovation.

Clearly, a major weakness for the MEDDAC is poor communication. When asked what could be done to improve the MEDDAC, respondents cited "improve communication" four times more often than the next most frequently cited recommendation. The majority of the respondents felt that, at best, they only sometimes knew what was going on in the MEDDAC. Several of those who mentioned communication problems noted that the "senior leadership does not listen." It is likely that the weaknesses noted in leadership and innovation are attributable, in part, to poor communication.

Analysis of Committee Minutes

Minutes of the MEDDAC Executive Committee meeting, Joint Staff meeting, Administrative Chiefs meeting, Quality Assurance Committee meeting, Enlisted Troop Action Council meeting, and Junior Enlisted Troop

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Action Council meeting from January 1990 through January 1991 were reviewed (subject to availability). Several quantitative measures were identified and analyzed for each set of minutes. A summary of each analysis follows.

Executive Committee. The Executive Committee is composed of the Commander; DCA; DCCS; Deputy Commander for Veterinary Services (not considered part of the command group for purposes of this study); Chief, Department of Nursing; Dental Activity Commander; and Command Sergeant Major. The committee meets monthly to review and approve the minutes of subordinate committees, review actions pending, and discuss items of interest. Meetings are conducted according to a structured format, but allow for open discussion and consideration of non-agenda items.

Minutes of the seven Executive Committee meetings held prior to the onset of Operation Desert Shield and the five meetings held during the operation were reviewed. The number of attendees, number of new issues discussed, and duration of each meeting were recorded as indicators of the level of communication. The number of times each committee member's name was mentioned in the minutes was recorded as an indicator

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of each members relative influence within the committee. The percentage of issues which related directly to Operation Desert Shield was recorded to provide an indication of the degree of attention this issue received. The results of this analysis are at Appendix E.

The attendance and the number of issues addressed at Executive Committee meetings declined negligibly during Operation Desert Shield. The decline in average meeting duration was noteworthy, falling from 42.14 minutes prior to Desert Shield to 33 minutes during the operation. Not surprisingly, the Commander's name was the one listed most often in the minutes. Of the total number of names cited in minutes, the Commander's name accounted for 42 percent prior to Desert Shield. This increased to 46 percent during Desert Shield. Thirty-seven percent of the issues discussed at Executive Committee meetings held from August 1990 through January 1991 directly involved support of Operation Desert Shield.

Discussion. The review and analysis of Executive Committee minutes yielded a couple of interesting trends. The meetings held during Operation Desert Shield were significantly shorter than those held prior

to the operation. This implies a decrease in the amount of communication occurring at the meetings held during Operation Desert Shield. It is inappropriate to consider shorter meetings "bad," simply because they are short. The communication which has apparently been eliminated from these meetings might have been social (chewing the fat) rather than official in nature. This interpretation is supported by finding that the average number of issues addressed remained relatively constant.

The second potential trend reflected in the Executive Committee minutes is an increase in the influence exerted by the Commander. Support for this notion is rather weak since the mention of the Commander's name increased by only four percent.

It is difficult to establish clear trends on the basis of the minutes of one committee. However, the review of the Executive Committee minutes did reveal changes occurring within the organization apparently as a result of Operation Desert Shield.

Joint Staff Meeting. The Joint Staff meeting is a meeting of the chiefs of clinical departments, separate services, and administrative divisions, and members of the special staff. The meeting is normally held

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monthly and is chaired by the MEDDAC Commander. The Joint Staff meeting primarily serves as a forum for information sharing.

Minutes were obtained for each Joint Staff meeting held from January 1990 through January 1991. The quantitative measures recorded for each meeting include: number of attendees, number of issues discussed, percentage of total issues which were attributed to members of the command group, and number of issues directly related to Operation Desert Shield. The results of this analysis are at Appendix F.

The average attendance at the six Joint Staff meetings preceding the onset of Operation Desert Shield was 25.5 people. The average for the four meetings held during Operation Desert Shield was 22.75 people. Before Desert Shield, an average of 46.3 issues were discussed at each meeting and meetings averaged 49.2 minutes in duration. During Desert Shield, the average number of issues discussed at each meeting fell to 38, while the average duration declined to 45.5 minutes. Before Desert Shield, 34.58 percent of the issues raised at each meeting were attributed to members of the command group (Commander, DCA, DCCS, and CSM). During Desert Shield, the proportion of issues raised

by members of the command group increased to 48.75 percent. An average of 32.5 percent of the issues discussed at meetings held during Operation Desert Shield dealt directly with support of this operation.

Discussion. The literature of organizational change indicates that organizations generally take one of two courses of action when they encounter environmental change. Organizational leaders either attempt to tighten their grip on the organization, reestablishing their control over it or they loosen the reins and seek to generate innovation and participation through improved communication and participative leadership (Hornstein 1986; Hill, 1989). The latter is depicted as the favored, though not necessarily most frequently followed, course.

The analysis of Joint Staff Meeting minutes lends support to the notion that the MEDDAC has followed the course of tightening control. The decline in attendance at the Joint Staff meeting could indicate less participation by the higher level staff. The decline in the number of issues discussed and duration of meetings indicates that perhaps communication has deteriorated. Innovation requires open communication and staff participation. If there has been a decline

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in communication and participation, organizational innovation may be assumed to have suffered as well. Members of the MEDDAC command group raised a significantly higher percentage of the issues at meetings during Desert Shield than they had before the onset of the operation. This is rather strong evidence of increased control by the command group. The MEDDAC's focus on supporting Desert Shield is evidenced by the finding that one-third of each meeting was devoted to this subject.

As a result of Operation Desert Shield, the Joint Staff meeting lost many of its traditional members and gained several new ones. This fact supports a contrary view that the observed deviations were due not to efforts of the command group to reestablish control but simply to the change in Joint Staff membership. New members may have been less willing to attend meetings and hesitant to speak up at the meetings they did attend. It is likely that these issues contributed to some degree to the differences noted above.

Administrative Chiefs' Meeting. The Administrative Chiefs' meeting is a meeting of the chiefs of the MEDDAC's administrative divisions and members of the special staff. The meeting is held

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bi-weekly and is chaired by the Deputy Commander for Administration. Like the Joint Staff meeting, the Administrative Chiefs' meeting is primarily a forum for information sharing.

Minutes were obtained for the thirteen Administrative Chiefs' meetings held prior to the onset of Desert Shield and the nine meetings held during Desert Shield. The measures taken were the same as those used for the Joint Staff meeting: attendance, duration, number of issues raised, percentage of issues raised by members of the command group, and percentage of issues involving support of Operation Desert Shield. The results of the analysis are at Appendix G.

The average attendance at Administrative Chiefs' meetings prior to Desert Shield was 19.15 people. During Desert Shield, the average rose to 21.22 people. Meetings lasted an average of 59.23 minutes and 46.08 issues were discussed prior to Desert Shield. During Desert Shield, meeting duration dropped to 41.11 minutes and 20.44 issues were discussed. The DCA raised 23 percent of the issues prior to Desert Shield and 29 percent of the issues during Desert Shield. In

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meetings held from August 28, 1990 through January 22, 1991, 18.6 percent of the issues discussed dealt directly with support of Desert Shield.

Discussion. The results of the analysis of the Administrative Chiefs' meeting seem to generally indicate a move toward tighter control. While attendance increased during Desert Shield, the number of issues discussed and the duration of meetings declined significantly. The percentage of issues attributed to the DCA also increased.

A change in the recorder for the Administrative Chiefs' meeting occurred two meetings prior to the onset of Operation Desert Shield. The deviations noted may be due in part to differences in the minute-taking styles of the two recorders. However, the recorder had no effect on meeting duration, which declined during Desert Shield. Therefore, the apparent decline in the level of communication occurring at the Administrative Chiefs' meeting should not be entirely attributed to differences in recorder styles.

Quality Assurance Committee. The Quality Assurance Committee is chaired by the DCCS and composed of the DCA, the Chief of Patient Administration Division, and the chiefs of the clinical departments

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and separate services. The meeting is regularly attended by a number of non-voting members including the Quality Assurance Coordinator, the Risk Management Coordinator, the Patient Representative, the MEDDAC's legal advisor, and others. Various other members of the MEDDAC staff sometimes attend the meeting. The meeting is held monthly.

The Quality Assurance Committee serves as a forum in which to monitor and evaluate the quality of care provided in the MEDDAC. It is an advisory committee to the MEDDAC Commander. The committee's meetings follow a structured format, covering such matters as death reviews, case reviews, blood usage reviews, drug usage reviews, and documentation reviews. The meeting format allows for the presentation of miscellaneous departmental issues and for reports from various subcommittees. The format provides a mechanism through which to identify and discuss problems and track issues of concern.

The Quality Assurance Committee discusses problems and potential problems and identifies issues which require monitoring and/or re-evaluation. The number of substantive issues (other than routine reports) discussed at each meeting provides an indication of the

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level of communication occurring within the MEDDAC. Issues were identified as substantive if they related to a specific problem or issue which crossed departmental boundaries. The attendance and duration of each meeting were also measured.

Minutes of the seven Quality Assurance Committee meetings held prior to Desert Shield and the five held during Desert Shield were reviewed. The average attendance at meetings held prior to Desert Shield was 16.86 people. During Desert Shield, this number increased to 17.4 people. Meetings lasted an average of 42.14 minutes and 7.29 issues were addressed prior to Desert Shield. Meeting duration declined to 27 minutes and an average of 5 issues were addressed during Desert Shield.

Discussion. The Quality Assurance Committee saw a slight increase in attendance, while meeting duration and issues covered declined. Again, this appears to indicate a diminution of communication.

There was a significant turnover among the members of the Quality Assurance Committee during Operation Desert Shield. The staff turnover probably had some influence on the trends noted above. New members might not have fully understood the purpose of the committee

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and might have been reluctant to raise issues. However, the large influx of new clinical staff members might have been expected to generate numerous problems and other cross-departmental issues. The minutes of the Quality Assurance Committee do not reflect such an increase. In fact, they give the appearance that things in the MEDDAC were moving along more smoothly during Desert Shield than had been the case prior to the operation.

Enlisted Troop Action Council. The Enlisted Troop Action Council is chaired by the CSM and normally meets monthly. The council is composed of enlisted representatives from each section of the MEDDAC. It serves as a forum for information sharing, discussion of matters which concern enlisted soldiers, and presentation of problems which involve enlisted soldiers. The CSM advises the Commander on issues raised by the council.

The researcher was able to obtain only five months of minutes for the Enlisted Troop Action Council; three for meetings held prior to Desert Shield and two for meetings held during Desert Shield. Analysis of this very limited sample of minutes revealed that average attendance increased from 8.67 prior to Desert Shield

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to 10.5 during Desert Shield. The average number of issues addressed increased from 7.3 to 14 per meeting, while the average meeting duration declined from 35 minutes to 30 minutes. Meetings scheduled for August and September 1990 were cancelled due to Operation Desert Shield (H. B. Fairchild, personnel communication, 16 April 1990).

Discussion. It would be inappropriate to draw conclusions based upon this limited sample of Enlisted Troop Action Council minutes. However, there are two points which are worth noting. First, the cancellation of meetings scheduled for August and September are incongruent with actions which might be expected of an organization striving to improve communication, increase participation, and generate innovation. This lends evidence to the argument that rather than adopting organic characteristics, the MEDDAC tightened control in the face of extreme environmental change.

The second point to note is that no mention of Operation Desert Shield or issues directly relating to Desert Shield were evident in the minutes of the two meetings held after the onset of the operation. MEDDAC leaders clearly defined the MEDDAC's mission priority by giving Desert Shield significant attention at higher

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level meetings. However, the emphasis on this issue might not have reached the enlisted staff level.

Junior Enlisted Troop Action Council. The Junior Enlisted Troop Action Council (JETAC) is composed of junior enlisted soldiers (E-4 and below). Membership in the JETAC is voluntary. The council meets on-call and is chaired by an elected member. The JETAC is primarily a social organization which meets to plan functions for the junior enlisted soldiers. It also serves as a forum for discussion of matters of interest to junior enlisted soldiers.

Minutes of four JETAC meetings held prior to Desert Shield and four held during Desert Shield were reviewed. The attendance, number of issues discussed, and duration of each meeting were recorded.

The average attendance at JETAC meetings held prior to Desert Shield was six members. This number declined to five during the operation. On average, 7.75 issues were discussed during meetings which averaged 53.75 minutes in duration prior to Desert Shield. After the onset of Desert Shield, the number of issues discussed dropped to 5.25 and average meeting duration declined to 20 minutes. Desert Shield was not discussed at any of the meetings.

Discussion. It would be inappropriate to draw conclusions based upon this analysis of JETAC minutes. The sample consisted of minutes of eight meetings, however, the quality of these minutes was poor. In one case, a single set of minutes was prepared to cover three meetings. Thus, it was difficult to draw information from the minutes and to discern between meetings. It is interesting to note, however, that once again no mention was made of Operation Desert Shield.

Discussion of Findings

A number of findings can be drawn from the preceding analyses. That the MEDDAC successfully accomplished its mission during Operation Desert Shield is among the clearest of these findings. The staff almost unanimously indicated that the MEDDAC had performed its mission well, with the vast majority describing its mission performance as very effective. Although some disturbing trends are evident, the MEDDAC's successful mission performance is the point to be remembered. Its performance could have been better in several areas which will be highlighted. However, it did complete its mission and certainly those outside the MEDDAC can garner more from studying the many

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things the MEDDAC did well (described in detail in Section 2) than from the things it did not do well. The criticisms offered here are presented as substantive research findings which offer the MEDDAC the opportunity to reflect upon its past performance and perhaps take actions to improve its future performance.

Changes obviously occurred within the MEDDAC during Operation Desert Shield. The changes most frequently cited in staff interviews involved personnel turnover and increased administrative work load. In some cases, existing processes were modified or new processes were created. The rule, however, seemed to be to train the new staff to use the existing processes which themselves remained basically unchanged.

The MEDDAC did not take the steps which might have been expected of an organization attempting to adapt to change. The MEDDAC Commander was characterized as an authoritarian leader. Rather than attempting to increase participation, the Commander and other members of the command group became more directive and controlling during Operation Desert Shield. The

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division and department chiefs noted that they also had tightened supervision of their areas to manage staff fluctuations and mission changes.

Communication in the MEDDAC was depicted as fair to poor and seemed to deteriorate during Operation Desert Shield. The MEDDAC staff noted that poor communication was a major problem. The command group did not agree on the reason for the communication problem. The Commander was frustrated that communication would not flow upward, while the DCA felt it did not flow downward as well as it should. The DCCS noted that, in his area, communication did flow upward but that he shielded the commander from it. The review of committee minutes revealed a clear trend of decreasing communication during Operation Desert Shield. Staff interviews also support a finding of deteriorating communication during Desert Shield.

On the basis of staff interviews, it appears that staff participation in the operation of the MEDDAC might have increased slightly during Operation Desert Shield. However, the analyses of committee minutes indicate that the Commander and command group assumed a larger role in these committees, while other staff members had less input. Therefore, it is difficult to

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determine the exact nature of the change in staff participation which came about as a consequence of the MEDDAC's support of Operation Desert Shield.

Although the Commander and command group pronounce their receptiveness to new ideas and innovation, the results of the formal data analysis indicate that, in many ways, the MEDDAC does not welcome innovation. The senior MEDDAC staff expressed a reluctance to come forward with suggestions or criticism. Their reluctance may be due to experience. Among those who said they had criticized a decision, most noted that the decision had not been changed. In the random interviews, staff members noted that while they were willing to offer suggestions, they were not confident their ideas would generate action. Finally, the communication flow, depicted as generally downward, may be assumed to have an adverse effect on both innovation and participation.

The MEDDAC's success during the period of Desert Shield is certainly due in part to the emphasis it placed on supporting this operation. Support of Desert Shield was a major topic of discussion at most of the key MEDDAC staff meetings. The Commander and other members of the command group noted that while

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their jobs did not change as a result of Desert Shield, their efforts became more "mission-focused." The division and department chiefs noted a change in orientation toward increased readiness and support of active duty soldiers.

IX. Application of the Model

Kotter's Model of Organizational Dynamics, introduced in chapter III, is used in this chapter to project an image of the MEDDAC. The model provides a format through which to examine the dynamics created by the MEDDAC's support of Operation Desert Shield. It also offers a theoretical base upon which to consider the potential moderate and long-run impact this event could have upon the MEDDAC.

Kotter (1978) maintains that an organization's performance is determined by its ability to create a favorable exchange relationship with members of its external environment. That is, to import more resources than it uses in producing goods or services. The MEDDAC must, therefore, provide a service more valuable to its stakeholders (i.e., American citizens, military beneficiaries, members of the 24th Division, local residents) than the cost of the resources it uses.

Key Organizational Processes

The matter/energy process. The services the MEDDAC provides include health care to military beneficiaries, improved readiness for the Army, employment to local residents, and commerce with the

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local community. The base resources imported by the MEDDAC are money and labor. Its annual operating budget is \$27 million and its military workforce numbers 550 officer and enlisted personnel. The MEDDAC uses money to buy additional labor and materiels (supplies, equipment, and facilities). These serve as inputs to its matter/energy conversion processes which yield health care services and the capacity to meet contingency expansion requirements. The MEDDAC's treats an average of 7,400 inpatients and supports almost 400,000 outpatient visits annually. The MEDDAC's expansion mission is classified.

The information process. The MEDDAC's command and control structure determines, to a great extent, the MEDDAC's success in meeting its care-provision and readiness missions. Command and control, in the parlance of the model, is an information process. Kotter (1978) holds that in most formal organizations, the key to generating matter energy surplus lies in information processes.

The MEDDAC has a hierarchical command and control structure consisting of a headquarters and subordinate clinical departments and administrative divisions. The MEDDAC Commander has a great deal of autonomy in

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operating the MEDDAC. The Commander is accountable to the Commander of the 24th Division and the Commander of Health Services Command. He has coordinating responsibilities with the Commander of Eisenhower Army Medical Center.

Structural Elements

The external environment. The external environment can be divided into a task environment and a wider, or general environment. The MEDDAC's task environment consists of the members of the 24th Division and residents of the local community. It includes such factors as the local economy, demographics of the beneficiary population, and the capability of other local health care providers. The MEDDAC's general environment includes the national economy, the Army and Department of Defense, the national health care system, and the world political situation.

Within recent years, the MEDDAC's task environment has been relatively static, while its general environment has undergone significant changes. Neither the characteristics nor the mission of the 24th Division has changed significantly. The local community has grown somewhat, as has the beneficiary

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population. The local community remains medically indigent and the military community continues to rely heavily on the MEDDAC to meet its health care needs. Nationally, changes have been more pronounced. The mission of the Army has begun to change as the Soviet threat subsides. The Department of Defense has sought increased efficiency, particularly within its medical components, by attempting to introduce competitive forces where none have existed previously. The capability and technological sophistication of health care providers has steadily increased. The world political situation has become somewhat chaotic as repressive regimes have been overthrown and communism has begun to falter. Regional disputes remain and hostilities have broken out in many parts of the world. The Middle East has remained a boiler plate where anything is possible.

Employees and other tangible assets. The MEDDAC employs 950 personnel. It has 175 officers, 375 enlisted members, and 400 civilians. Approximately 70 percent of the MEDDAC's staff perform clinical functions with the remainder employed in various administrative and clinical support capacities. The hospital itself is a fairly new structure. Built in

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1983, the 341,000 square foot hospital has a licensed capacity of 165 beds. The MEDDAC employs a wide array of modern medical technology, but due to recent budgetary constraints, continues to rely on some equipment which is rapidly becoming outdated.

The MEDDAC's employees are a highly professional group, similar in education and skills to the staff of most other hospitals. Staff members of the MEDDAC perceive it as a good place to work and report friendly co-workers and a pleasant atmosphere. The MEDDAC experiences frequent turnover among its military staff. The turnover rate among civilian employees is much less than that of military employees. Civilian employees are widely recognized as providing continuity for the MEDDAC's longer-term operations

Formal organizational arrangements. The MEDDAC is a dichotomous organization consisting of clinical and administrative branches (see appendix J). Clinical elements fall under the Deputy Commander for Clinical Services and administrative elements under the Deputy Commander for Administration. This dichotomy is fairly rigid and forces a degree of separation upon the elements of the organization. The hierarchical arrangement is also rigid. Using the "chain of

"command" is emphasized and going outside of an individual's chain of command is strongly discouraged.

The MEDDAC uses personnel rating systems common to the Army. Officers, non-commissioned officers, and civilian employees are rated annually. Performance ratings are conducted according to proscribed formats, but are often quite subjective in nature. Performance standards, particularly for military personnel, may vary greatly between departments or divisions based upon the personal preferences of different supervisors.

Employee recognition and reward systems are an integral part of the MEDDAC's human resources management system. Like performance evaluations, employee recognition follows an Army-standard program. Military members may receive only nonmonetary awards. Civilian employees are eligible for both monetary and nonmonetary awards.

The social system. The social system consists of culture and social structure. Culture is made up of the norms and values shared among employees. The culture of the MEDDAC is characterized by friendliness, trust, appreciation of hard work, and the desire for personal improvement. This is the product of Army values and local societal norms. The social structure

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of the MEDDAC is greatly influenced by its command and control structure. Affiliation is closest among immediate work groups and then within departments and divisions and finally within administrative or clinical branches. The clinical side of the MEDDAC is the more powerful of the two branches.

Technology. The MEDDAC's core technology is hands-on patient care as practiced by its staff physicians. Various other techniques are used to support this core technology. Among these are nursing care, physical therapy, laboratory and radiology services, nutrition care, pharmacy services and others. Many administrative technologies are used in providing the necessary materiels and services to those who provide the core services. Among the administrative technologies in use by the MEDDAC are inventory management, purchasing and receiving, warehousing, budgeting, payroll, and training.

The dominant coalition. The dominant coalition of the MEDDAC is its Commander. The command group is an influential group within the MEDDAC, but it is clear from the results of the preceding analyses that the Commander's influence is such that he alone represents the dominant coalition.

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The Commander is an authoritarian leader who respects his staff's opinions and advice. He is a large man with a direct and sometimes, apparently unintentionally, threatening manner. The Commander generally follows a rational, well-defined decision-making process which relies upon staff input. He does, however, make decisions unilaterally in some situations.

Short-run Dynamics Within the MEDDAC

Short-run organizational dynamics occur within a period of a few hours to six months. They take place among structural elements and between structural elements and organizational processes (Kotter, 1978). The impact of the Operation Desert Shield should be evident upon examination of these parts of the model.

The decision to respond to the Iraqi invasion of Kuwait with military force created a period of dramatic change. The 24th Division and other military units prepared for deployment, deployed to Saudi Arabia, and commenced military operations within a period of approximately six months. During that six month period, the MEDDAC encountered many changes as well. The MEDDAC released its PROFIS physicians, received and employed backfill physicians, released backfill

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physicians and integrated activated reservists, supported active and reserve mobilizations, and expanded its capacity in preparation for war.

The Iraqi invasion of Kuwait and the American response created a drastic change in the MEDDAC's general environment. The invasion of oil-rich Kuwait carried tremendous political and economic implications for the rest of the world. Within a matter of days, the situation had impacted upon the MEDDAC's task environment as the 24th Division prepared to deploy.

The Commander (dominant coalition) responded to these events by tightening his grip on the organization. The nursing report was dispensed with at morning meetings so the Commander and staff could discuss the MEDDAC's role in supporting the pending deployment. Routine meetings were cancelled and ad hoc meetings, called by the Commander, became the order of the day.

The Commander's actions resulted in immediate changes in the MEDDAC's key processes. Information processes, previously focused on gathering information with which to manage patient care, shifted immediately. Gathering information with which to assess the situation and determine what support would be required

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became the new focus. Matter/energy processes also experienced change. Patient care was interrupted as physicians prepared for deployment. Backfill physicians and reservists were unaccustomed to the modes by which various clinics and departments operated. The inpatient census dropped and planning and training activities took on new importance as the MEDDAC shifted its focus toward readiness. The MEDDAC's Logistics Division provided direct support to deploying units and the Department of Nursing picked up responsibility for operation of the troop medical clinics. Throughout the organization, a shift toward readiness and soldier support was noted.

The MEDDAC's social system experienced something of a realignment as the operation progressed. As the senior members of the clinical staff departed and the emphasis shifted from patient care to readiness, the organization began to depend more heavily upon its administrative elements. Because of this reliance, the administrative elements gained increased credibility and power. The social structure also changed as a third element, the reservists, broke the clinical-administrative dichotomy. The organizational structure remained unchanged, but the presence of a

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large body of activated reservists among both administrative and clinical elements created a bit of a we-they situation.

The MEDDAC experienced continuing turbulence in the form of personnel turnover and changing mission requirements. The Commander responded to this turbulence by becoming more directive. He took direct control of most of the programs through which the MEDDAC supported the ongoing operation (i.e., PROFIS, SRP, deployability examinations). Although increasing his reliance somewhat on his deputies, the Commander made practically all of the decisions regarding the MEDDAC's support of the deployment. He dominated planning meetings and personally wrote many plans. He directly issued assignments to his staff on a daily basis.

Many of the senior staff appreciated the Commander's firm leadership. He was not a hard man from whom to get a decision. The Commander's increasingly hands-on leadership style, described by many as "micromanagement," created a change in the MEDDAC's information process as carried out through its command and control structure. Chiefs of divisions and compartments began to rely upon the Commander to

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establish their priorities. Instead of gathering information, interpreting and acting upon it, the staff endeavored to "have the information the old man would want." Staff members would present information to the Commander, discuss it with him, and take the action he directed. This mode of organizational decision making worked well during Desert Shield due to the Commander's foresight and involvement. It resulted in a diminution of the staff's initiative, however, as they became more reliant upon the Commander.

The formal organizational arrangements became less formal during Operation Desert Shield. Many staff members reported a renewed sense of teamwork. Facing the monumental tasks involved in supporting the deployment of the division and the mobilization of thousands of reservists, many sections of the MEDDAC pulled together to get the job done. The MEDDAC made extensive use of its reward system to recognize individual performance.

While the MEDDAC did experience extensive personnel turnover, it continued to rely on the same basic processes. Readiness functions such as planning and training took on increased importance, but hands-on patient care remained the MEDDAC's core technology.

Potential Moderate-run Dynamics in the MEDDAC

Moderate-run dynamics occur in organizations over periods of six months to six years. Moderate-run dynamics are determined by the degree of alignment or "fit" which exists between the structural elements of the model. As the organization encounters changes, nonalignments among the structural elements occur creating inefficient matter/energy processes and ineffective decision-making processes. When nonalignments arise, the states of the structural elements change over a period so that the relationships are once again aligned. The speed with which this realignment occurs is determined largely by how much waste the organization's external environment and dominant coalition are willing to tolerate. (Kotter, 1978).

One of the most common causes of structural nonalignments is environmental change. The environmental change brought on by Operation Desert Shield resulted in a number of problems which emerged and were handled by the MEDDAC. These short-run dynamics resulted in changes in many of the structural elements. These changes could cause nonalignments to arise over the moderate-run period.

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The external environment has clearly changed. The strong performance of the armed forces and tremendous public support for Operation Desert Shield destroyed many post-Vietnam myths. Although still difficult to predict, the general environment is now characterized by a greater social acceptance of the use of military force. Similarly, the MEDDAC's task environment changed with the deployment of the 24th Division and use of Fort Stewart as a mobilization station. Readiness, not only for combat units but for all elements of Fort Stewart, now receives heightened attention.

The changes already evident in the post-Desert Shield external environment could create nonalignments between the environment and other structural elements. The MEDDAC's core technology has always been hands-on patient care practiced in the hospital. It is likely that exclusive reliance upon this technology will not "fit" with the increased readiness orientation of the external environment. By changing its technology slightly, however, the MEDDAC can meet both patient care and readiness requirements. Through its new Coordinated Care Division, the MEDDAC can begin to manage beneficiary care between its military assets and

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contracts with civilian providers. It must calculate increased training time into its formulae for determining which and how many cases it will keep in-house. The MEDDAC's core technology may then become two-part: a patient-care and training technology and a care coordination technology. Prudent management of the coordinated care program offers the MEDDAC the potential to handle increased training requirements while still meeting its patient-care mission.

The MEDDAC's dominant coalition has been characterized by authoritarian leadership. The Commander's directive leadership style has created a dependent relationship between the Commander and staff. Rather than the Commander being dependent upon his staff, however, the staff has become overly reliant upon the Commander. If the successor to command at the MEDDAC practices a participative leadership style, a nonalignment is likely to develop between the dominant coalition and the MEDDAC employees.

As readiness takes on increasing importance, several formal organizational arrangements will likely change to relieve nonalignments. The Professional Officer Filler System will certainly be more closely managed if not replaced. A MEDDAC and Army more

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oriented to readiness must have a reliable plan for attaching trained medical personnel to deploying units and backfilling upon their departure. The MEDDAC's Mobilization and Expansion plan is also likely to be revised based upon lesson learned during Operation Desert Shield.

Changes in the MEDDAC's social structure may occur, driven by changes in its external environment and technology. The MEDDAC's increasing emphasis on readiness could lessen the distance between the clinical and administrative branches. All members of the MEDDAC will likely participate in training activities. Administrative and clinical branches will have to work together to develop and practice realistic contingency plans. The emphasis on readiness and growth of coordinated care may contribute to an increase in the stature of the administrative branches. This may yield a social structure in which power and prestige are more evenly distributed between the administrative and clinical branches.

Potential Long-run Dynamics in the MEDDAC

Long-run organizational dynamics occur over a period of six to sixty years. They are a function of the driving force of the organization and the states of

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the structural elements. The driving force is that structural element (or those elements) which has the greatest influence on the organization. As it moves, other structural elements follow to maintain alignment. The states of the structural elements of an organization can range from constraining of organizational processes and hard to align to unconstraining and easy to align. (Kotter, 1978).

The key to an organization's long-run survival lies in its ability to adapt to change. If the structural elements are constraining of organizational processes, the organization will have difficulty adapting to change. As changes occur, nonalignments arise and the structural elements must realign to adapt. If the elements are very constraining, they will realign slowly or not at all. Thus, energy will be lost. If this happens repeatedly, in the long-run the organization will die. (Kotter, 1978).

The driving force within the MEDDAC has been its employees and the formal organizational arrangements. The employees of the MEDDAC, particularly the civilian employees, provide it continuity. While the dominant coalition changes depending upon the manner of the Commander, the employees remain relative constant. The

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MEDDAC's formal organizational arrangements are, for the most part, dictated by Army policy. They are largely beyond the control of MEDDAC leaders and are designed to ensure the MEDDAC operates in a consistant manner, similar to other Army MEDDACS.

The driving force of the MEDDAC has led it to operate in a fairly consistant, uniform manner. An organization's employees naturally resist change. Many of the MEDDAC's formal organizational arrangements were designed to assure the it does not change (i.e., the MCCU reimbursement system, the mission template). Thus, the driving force of the MEDDAC has caused it to be a change-resistant organization over the long-run.

The radical change of Operation Desert Shield, combined with potential changes in the MEDDAC's technology and formal organizational arrangements, could yield a newly change-responsive MEDDAC. During Desert Shield, the external environment became the dominant structural element. Desert Shield drove home the need for the MEDDAC, the Army, and the nation to continually and carefully monitor the environment. As the coordinated care concept and Gateway program are introduced, it is likely the environment will continue to be a very important structural element. The MEDDAC

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will need to monitor its environment from an economic standpoint as it adopts competitive characteristics. The Gateway program also has implications for the MEDDAC's formal arrangements and technology. The program will loosen a number of restrictive arrangements imposed by the Army and Health Services Command. The introduction of the Gateway program could lead to changes in the MEDDAC's core technology. It could well become both a provider of services and an intermediary coordinating services for its beneficiaries. Thus, patient care and management of beneficiary health services could become the MEDDAC's dual technologies.

A more general, and perhaps more precise, projection of the MEDDAC's long-run effectiveness can be gained by considering the current states of its structural elements. The MEDDAC relies on a core technology which is probably on par with that of most community hospitals. However, the MEDDAC lacks the sophistication in its administrative processes to efficiently manage its core technology. That is, the MEDDAC relies on an outmoded resourcing system, it does not have an integrated system for producing and distributing management information, and it relies upon

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rather crude measures of productivity, patient satisfaction, and overall performance. Management of the Gateway program and its coordinated care initiatives will require even greater administrative sophistication. Therefore, the MEDDAC's technology stands as a potentially constraining structural element.

The MEDDAC's social system probably supports its ability to adapt to change. Employees report a high degree of satisfaction with the organization. They enjoy their jobs, friendly coworkers, and pleasant environment. Adaptability to change is not a shared value, however, the seemingly high morale and trust within the organization should enhance its ability to adapt to change.

The employees and other tangible assets both support and inhibit the MEDDAC's ability to adapt to change. The MEDDAC's administrative employees lack some of the skills which will be necessary to operate successively in a competitive environment. However, the employees seem eager to learn, frequently citing the desire for continuing education. The MEDDAC's

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physical plant is fairly new and in sound condition. Unfortunately, though, much of its internal equipment is aging.

The formal organizational arrangements are becoming less constraining and should begin to support the MEDDAC's ability to adapt to change. The MEDDAC's dominant coalition must also loosen its reins on the organization. Kotter (1978) suggests that a dominant coalition which facilitates change is one characterized by: "A large, reasonably heterogeneous yet cohesive group of people of different ages who work together well and have plenty of effective leadership."

Finally, the external environment will demand that the MEDDAC become more adaptive. Yet, as a structural element it will not necessarily facilitate change. The world political situation is likely to remain unpredictable making contingency planning difficult. Rising health care costs will generate pressure to reduce services. Army manpower cuts could lead to staff reductions. Thus, the uncertainty present in the external environment makes increased adaptation anything but an easy proposition.

X. Conclusions and Recommendations

The USA MEDDAC at Fort Stewart, Georgia, performed exceptionally well during Operation Desert Shield in spite of failing to assume the adaptive characteristics suggested by the literature. The MEDDAC continued to provide care to local beneficiaries throughout Operation Desert Shield. It simultaneously supported the mobilization and deployment of thousands of soldiers and expanded to meet its contingency mission requirements. Rather than assuming organic characteristics, as was suggested, the MEDDAC became more mechanistic in its support of the operation.

The non-responsiveness to change noted in the MEDDAC apparently did not adversely effect its ability to accomplish its mission during Operation Desert Shield. Communication within the MEDDAC decreased during the operation. Organizational decision-making became more unilateral. Participation in management apparently declined and organizational innovation can be assumed to have suffered. Yet, the MEDDAC did accomplish its mission during this period of dramatic change and uncertainty.

The MEDDAC implemented some internal changes in response to the changes in its external environment.

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The internal changes were, however, not of the degree or scope which might have been anticipated. Few structural changes were made and most processes remained unchanged. For the most part, the MEDDAC simply tightened control of its existing structures and processes.

The Commander directly managed the key aspects of the MEDDAC's operations in support of Desert Shield. Although relying upon his deputies for increased support, he did not seem to have difficulty providing direct leadership. His leadership style remained authoritarian and became even more directive during the operation.

The MEDDAC performed extremely well during Operation Desert Shield. However, during this analysis a number of organizational weaknesses became apparent. The MEDDAC suffers from poor communication. The generally downward flow of communication stifles participation and innovation as does a perception that the command group doesn't listen to its subordinates. The Commander's leadership style has yielded positive results but may be fostering a dependence within the staff. The lack of completely uniform agreement on the MEDDACs mission by division and department chiefs could

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mean that some elements of the MEDDAC are working toward different ends. Many departments and divisions lack clear objectives designed to support the MEDDAC's mission. These issues and others must be addressed if the MEDDAC is to maintain its strong performance.

The MEDDAC's actions in support of Operation Desert Shield should be studied by Army Medical Department planners. The MEDDAC's performance should be used as a model upon which to base plans to support divisional deployments and reserve mobilizations. The MEDDACS management of the Soldier Readiness Process and deployability examinitions, and general support of mobilization activities should receive particular attention. The problems the MEDDAC encountered should be identified and procedures developed to avoid them in future mobilization situations.

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Appendix A

Interview Format A

(for members of the command group)

1. Please describe your job.
2. Has your job changed as a result of Operation Desert Shield? In what ways?
3. Has Operation Desert Shield brought about any changes in the way this MEDDAC does business? Have there been any structural changes within the MEDDAC? Has there been any change in the way you get things done?
4. How would you describe your leadership style? Has it changed since Desert Shield?
5. How involved are you in the daily operations of this MEDDAC? Has this changed since the onset of Operation Desert Shield?
6. Please describe your decision making process.
7. With the onset of Operation Desert Shield, do you rely more or less on input from the staff in making decisions.
8. Do you feel the commander has relied more or less on your input since the onset of Operation Desert Shield? (This will not be asked of the commander)
9. How good are communications within the MEDDAC?

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Appendix A (continued)

10. Would you describe the communication flow as primarily top-down, bottom-up, or as flowing both ways equally?
11. Have communications improved since the onset of Operation Desert Shield? If so, how?
12. Does the staff feel comfortable suggesting new ways of doing things? Are good suggestions frequently acted upon?
13. What, in your own words, is the mission of this MEDDAC?
14. Has the mission changed since the onset of Operation Desert Shield?
15. How do you measure the effectiveness of the MEDDAC in meeting its mission?
16. How effective has the MEDDAC been in meeting its mission?

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Appendix B

Interview Format B

(for division chiefs)

1. Please describe your job.
2. Has your job changed since the onset of Operation Desert Shield? In what ways?
3. Has Operation Desert Shield resulted in any changes in the way this division does business? Have there been any structural changes within the division? Has there been any change in the way you get things done?
4. How would you describe the commander's leadership style? Has it changed since the onset of Operation Desert Shield?
5. Does the commander rely more or less on other members of the command group since the onset of Operation Desert Shield, or has there been no change?
6. How involved is the commander in the daily operations of the MEDDAC? Has this changed since the onset of Operation Desert Shield? Is this a positive change? Why or why not?
7. How involved are other members of the command group in the daily operations of the MEDDAC? Has this changed since the onset of Operation Desert Shield? Is this a positive change? Why or why not?

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Appendix B (continued)

8. Do you feel the command group has relied more or less on your input since the onset of Operation Desert Shield?
9. Would you feel comfortable in going to your boss (DCA or DCCS) and suggesting a new way of doing something? Do you think it would be acted upon?
10. Do you feel free to criticize decisions made by the commander or command group? Do you think the commander or command group would reconsider a decision based upon criticism from you? Have you ever gone to the commander or a member of the command group to criticize a decision they made? If so, what was the reaction?
11. How good are communications within the MEDDAC?
12. Would you describe the communication flow as primarily top-down, bottom-up, or as flowing both ways equally?
13. Have communications improved since the onset of Operation Desert Shield?
14. What, in your own words, is the MEDDAC's mission?
15. How does this affect you and your division?

Appendix B (continued)

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16. Has the mission changed with the onset of Operation Desert Shield? How?
17. How effective has the MEDDAC been in accomplishing its mission?

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Appendix C

Interview Format C

(for randomly selected MEDDAC employees)

1. Is this MEDDAC a good place to work? Why or why not?
2. How do you like your job? What do you most like about it? What do you most dislike about it?
3. Have you noticed any changes in your ward/clinic/office in the last six to eight months? Tell me about them.
4. Do you feel that you know what's going on in the MEDDAC? How do you find out what's going on?
5. If you had a good idea about how to do something better or easier, what would you do about it? Do you think any action would be taken as a result of this?
6. What is the mission of this MEDDAC? What are the objectives of your ward/clinic/office?
7. How effective has the MEDDAC been in accomplishing its mission?
8. What one thing could be done to improve this MEDDAC?

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Appendix D

Analysis of Responses to Interview Format C

1. Is this MEDDAC a good place to work? Why or why not?

	<u>Administrative</u>	<u>Clinical</u>	<u>Totals</u>
Officer	Y: 4 N: 1 U: 0	Y: 5 N: 0 U: 0	Y: 9 N: 1 U: 0
Why:	P: 1 *W: 3	P: 4 W: 1	P: 5 W: 4
Enlisted	Y: 4 N: 0 U: 1	Y: 4 N: 0 U: 1	Y: 8 N: 0 U: 2
Why:	P: 3 W: 2	P: 2 W: 3	P: 5 W: 5
Civilian	Y: 4 N: 0 U: 1	Y: 5 N: 0 U: 0	Y: 9 N: 0 U: 1
Why:	P: 3 W: 2	P: 3 W: 2	P: 6 W: 4
Totals	Y: 12 N: 1 U: 2	Y: 14 N: 0 U: 1	YES: 26 NO: 1 UNSURE: 3
Why:	P: 7 W: 7	P: 9 W: 6	PEOPLE: 16 WORK: 13

* one respondent disliked working in the MEDDAC

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Appendix D (continued)

2. How do you like your job? What do you most like about it? What do you most dislike about it?

	<u>Administrative</u>	<u>Clinical</u>	<u>Totals</u>
Officer	L: 2 OK: 3	L: 4 OK: 1	L: 6 OK: 4
Like:	J: 4 HP: 1	J: 3 HP: 2	J: 7 HP: 3
Dislike:	J: 3 S: 1 WC: 1 P: 0 N: 0	J: 2 S: 2 WC: 1 P: 0 N: 0	J: 5 S: 3 WC: 2 P: 0 N: 0
Enlisted	L: 5 OK: 0	L: 4 OK: 1	L: 9 OK: 1
Like:	J: 3 HP: 2	J: 2 HP: 3	J: 5 HP: 5
Dislike:	J: 2 S: 1 WC: 1 P: 0 N: 1	J: 1 S: 2 WC: 2 P: 0 N: 0	J: 3 S: 3 WC: 3 P: 0 N: 1
Civilian	L: 5 OK: 0	L: 5 OK: 0	L: 10 OK: 0
Like:	J: 4 HP: 1	J: 5 HP: 0	J: 9 HP: 1
Dislike:	J: 0 S: 2 WC: 1 P: 1 N: 1	J: 0 S: 2 WC: 2 P: 1 N: 0	J: 0 S: 4 WC: 3 P: 1 N: 1
Totals	L: 12 OK: 3	L: 13 OK: 2	LIKE IT: 25 IT'S OK: 5
Like:	J: 11 HP: 4	J: 10 HP: 5	JOB ASPECT: 21 HELP PEOPLE: 9
Dislike:	J: 5 S: 4 WC: 3 P: 1 N: 2	J: 3 S: 6 WC: 5 P: 1 N: 0	JOB ASPECT: 8 LACK SPT: 10 WORK COND: 8 PERSONAL: 2 NOTHING: 2

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Appendix D (cont.)

3. Have you noticed any changes in your ward/clinic/office in the last six to eight months? Tell me about them.

	<u>Administrative</u>	<u>Clinical</u>	<u>Totals</u>
Officer	Y: 4 N: 1 ?: 1	Y: 4 N: 0 ?: 1	Y: 8 N: 1 ?: 1
Enlisted	Y: 4 N: 0 ?: 1	Y: 5 N: 0 ?: 0	Y: 9 N: 0 ?: 1
Civilian	Y: 4 N: 1 ?: 0	Y: 5 N: 0 ?: 0	Y: 9 N: 1 ?: 0
Totals	Y: 12 N: 1 ?: 2	Y: 14 N: 0 ?: 1	YES: 26 NO: 1 DON'T KNOW: 3

Reasons:

Changed/New Process	13
Personnel Turnover	12
Increased Work load	12
Change in Working Conditions	6
Increased Training	5
Improved Morale/Teamwork	3
Decreased Morale	3
Decreased Workload	2

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Appendix D (cont.)

4. Do you feel that you know what's going on in the MEDDAC? How do you find out what's going on?

	<u>Administrative</u>	<u>Clinical</u>	<u>Totals</u>
Officer	Y: 4 S: 0 N: 1	Y: 1 S: 2 N: 2	Y: 5 S: 3 N: 2
How?	Supr: 3 Rumor: 0 Co-wkr: 3 BB/Dist: 1 Mtgs: 2	Supr: 3 Rumor: 2 Co-wkr: 2 BB/Dist: 0 Mtgs: 0	Supr: 6 Rumor: 2 Co-wkr: 5 BB/Dist: 1 Mtgs: 2
Enlisted	Y: 2 S: 1 N: 2	Y: 4 S: 1 N: 0	Y: 6 S: 2 N: 2
How?	Supr: 4 Rumor: 1 Co-wkr: 0 BB/Dist: 3 Mtgs: 2	Supr: 2 Rumor: 4 Co-wkr: 3 BB/Dist: 2 Mtgs: 1	Supr: 6 Rumor: 5 Co-wkr: 3 BB/Dist: 5 Mtgs: 3
Civilian	Y: 1 S: 2 N: 2	Y: 1 S: 3 N: 1	Y: 2 S: 5 N: 3
How?	Supr: 1 Rumor: 3 Co-wkr: 1 BB/Dist: 1 Mtgs: 3	Supr: 1 Rumor: 2 Co-wkr: 1 BB/Dist: 3 Mtgs: 1	Supr: 2 Rumor: 5 Co-wkr: 2 BB/Dist: 4 Mtgs: 4
Totals	Y: 7 S: 3 N: 5	Y: 6 S: 6 N: 3	YES: 13 SOMETIMES: 9 NO: 8
How?	Supr: 8 Rumor: 4 Co-wkr: 4 BB/Dist: 5 Mtgs: 7	Supr: 6 Rumor: 8 Co-wkr: 6 BB/Dist: 5 Mtgs: 2	SUPERVISOR: 14 RUMOR: 12 CO-WORKER: 10 BUL BD/DIST: 10 MTGS: 9

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Appendix D (cont.)

5. If you had a good idea about how to do something better or easier, what would you do about it? Do you think any action would be taken as a result of this?

	<u>Administrative</u>	<u>Clinical</u>	<u>Totals</u>
Officer	Supr: 1 Supr I/A: 1 Co-wkrs: 1 Nothing: 1 Cmd Grp: 1	Supr: 3 Supr I/A: 2	Supr: 4 Supr I/A: 3 Co-wkrs: 1 Nothing: 1 Cmd Grp: 1
Action?	Y: 2 M: 2 N: 1	Y: 2 M: 3 N: 0	Y: 4 M: 5 N: 1
Enlisted	Supr: 2 Supr I/A: 2 Sug Prog: 1	Supr: 3 Supr I/A: 2	Supr: 5 Supr I/A: 4 Sug Prog: 1
Action?	Y: 2 M: 2 N: 1	Y: 2 M: 2 N: 1	Y: 4 M: 4 N: 2
Civilian	Supr: 2 Supr I/A: 1 Sug Prog: 1 Don't Know: 1	Supr: 3 Supr I/A: 1 Sug Prog: 1	Supr: 5 Supr I/A: 2 Sug Prog: 2 Don't Know: 1
Action?	Y: 2 M: 0 N: 3	Y: 3 M: 2 N: 0	Y: 5 M: 2 N: 3
Totals	Supr: 5 Supr I/A: 4 Sug Prog: 2 Co-wkrs: 1 Cmd Grp: 1 Don't Know: 1 Nothing: 1	Supr: 9 Supr I/A: 5 Sug Prog: 1	SUPERVISOR: 14 IMPACT AREA: 9 SUGGS PROG: 3 CO-WORKERS: 2 CMMRD GROUP: 1 DON'T KNOW: 1 NOTHING: 1
Action?	Y: 6 M: 4 N: 5	Y: 7 M: 7 N: 1	YES: 13 MAYBE: 11 NO: 6

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Appendix D (cont.)

6. What is the mission of this MEDDAC? What are the objectives of your ward/clinic/office?

	<u>Administrative</u>	<u>Clinical</u>	<u>Totals</u>
Officers	All Bene: 3 Pat Care: 1 Sold/Fam: 1	All Bene: 2 Pat Care: 0 Sold/Fam: 2 Cons F/S: 1	All Bene: 5 Pat Care: 1 Sold/Fam: 3 Cons F/S: 1
*Objs:	General: 4 Specific: 1	General: 2 Specific: 3	General: 5 Specific: 4
Enlisted	All Bene: 2 Pat Care: 2 Sold/Fam: 1	All Bene: 0 Pat Care: 2 Sold/Fam: 1 Cons F/S: 1 1st Care: 1	All Bene: 2 Pat Care: 4 Sold/Fam: 2 Cons F/S: 1 1st Care: 1
Objs:	General: 2 Specific: 3	General: 2 Specific: 3	General: 4 Specific: 6
Civilian	All Bene: 2 Pat Care: 3	All Bene: 1 Pat Care: 2 Sold/Fam: 2	All Bene: 3 Pat Care: 5 Sold/Fam: 2
Objs:	General: 3 Specific: 2	General: 4 Specific: 1	General: 7 Specific: 3
Totals	All Bene: 7 Pat Care: 6 Sold/Fam: 2	All Bene: 3 Pat Care: 4 Sold/Fam: 5 Cons F/S: 2 1st Care: 1	ALL BENE: 10 PAT CAFE: 10 *SOLD/FAM: 7 *CONS F/S: 2 *1ST CARE: 1
Objs:	General: 9 Specific: 6	General: 8 Specific: 7	GENERAL: 17 SPECIFIC: 13

* Objs = Objectives

* Sold/Fam = Care for soldiers and their families.

* Cons F/S = To conserve the fighting strength.

* 1st Care = First to care.

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Appendix D (cont.)

7. How effective has this MEDDAC been in accomplishing its mission?

	<u>Administrative</u>	<u>Clinical</u>	<u>Totals</u>
Officer	V: 2 E: 1 M: 1 U: 1	V: 1 E: 2 M: 2	V: 3 E: 3 M: 3 U: 1
Enlisted	V: 2 E: 1 M: 2	V: 3 E: 2 M: 0	V: 5 E: 3 M: 2
Civilian	V: 3 E: 1 M: 1	V: 2 E: 2 M: 1	V: 5 E: 3 M: 2
Totals	V: 7 E: 3 M: 4 U: 1	V: 6 E: 6 M: 3	Very Effective: 13 Effective: 9 Moderately Eff: 7 Unsure: 1

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Appendix D (cont.)

8. What one thing could be done to improve this MEDDAC?

	<u>Administrative</u>	<u>Clinical</u>	<u>Totals</u>
Officer	Commo: 3 Appts: 1 AD Stf: 1 Spt: 0	Commo: 3 Appts: 1 AD Stf: 0 Spt: 1	Commo: 6 Appts: 2 AD Stf: 1 Spt: 1
Enlisted	Commo: 1 + Rep: 1 Ldrsp: 1 Cmd Pres: 0 Stf/\$: 1 + Park: 0 Persnl: 1	Commo: 3 + Rep: 0 Ldrsp: 0 Cmd Pres: 1 Stf/\$: 0 + Park: 1 Persnl: 0	Commo: 4 + Rep: 1 Ldrsp: 1 Cmd Pres: 1 Stf/\$: 1 + Park: 1 Persnl: 1
Civilian	Commo: 0 Appts: 1 Stf/\$: 1 + Rep: 1 Cmd Pres: 1 Courtesy: 1 Phys Scr: 0 Don't Kn: 0	Commo: 2 Appts: 0 Stf/\$: 1 + Rep: 0 Cmd Pres: 0 Courtesy: 0 Phys Scn: 1 Don't Kn: 1	Commo: 2 Appts: 1 Stf/\$: 2 + Rep: 1 Cmd Pres: 1 Courtesy: 1 Phys Scn: 1 Don't Kn: 1

Cumulative results of question 8:

Commo = Improve communication	12
Appts = Improve appointment system	3
Stf/\$ = Increase staff and/or resources	3
Cmd Pres = Increase command presence	2
+ Rep = Improve reputation w/ community	2
Ldrsp = Improve leadership	1
+ Spt = Improve support	1
Courtesy = Improve staff courtesy	1
Phys Scn = Improve physician screening	1
AD Stf = Return active duty staff	1
+ Park = Improve parking	1
Persnl = Personal	1
Don't Kn = Don't Know	1

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Appendix E

Analysis of Executive Committee Minutes

<u>Date</u>	<u>Number Attend</u>	<u>Time</u>	<u>Issues Addressed</u>	<u>Name Mentioned:</u>			
				<u>Cdr</u>	<u>DCA</u>	<u>DCCS</u>	<u>Oth</u>
26 Jan 90	9	70	27	15	6	10	1
02 Mar 90	8	55	20	8	2	5	6
30 Mar 90	8	40	20	7	2	5	5
27 Apr 90	6	40	18	9	2	9	1
25 May 90	5	25	17	*A	7	9	3
29 Jun 90	6	25	17	A	3	5	5
27 Jul 90	6	40	11	7	3	2	4
X	6.86	42.14	18.57	9.2	3.6	6.4	3.6
S	1.46	16.04	4.79	3.3	2.1	2.9	2.0
31 Aug 90	6	25	12	4	2	2	0
28 Sep 90	6	30	13	6	4	6	1
02 Nov 90	6	30	14	7	5	6	0
30 Nov 90	7	20	11	8	5	3	2
25 Jan 91	8	60	40	19	7	0	4
X	6.6	33	18	8.8	4.6	3.4	1.4
S	.89	15.65	12.35	5.9	1.8	2.6	1.67

A = Absent

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Appendix F

Analysis of Joint Staff Meeting Minutes

<u>Date</u>	<u>Number Attending</u>	<u>Time</u>	<u>Issues Addressed</u>	<u>Addressed by:</u>		
				<u>Cmd</u>	<u>Grp</u>	<u>Other</u>
11 Jan 90	29	45	58	23		35
15 Feb 90	25	60	46	11		35
15 Mar 90	23	50	52	27		25
12 Apr 90	28	75	49	12		37
14 Jun 90	22	30	33	9		21
12 Jul 90	26	35	40	15		25
X	25.5	49.2	46.3	16.67		29.67
S	2.7	16.6	8.9	7.2		6.8
11 Oct 90	19	57	51	23		28
15 Nov 90	25	20	30	10		20
13 Dec 90	21	45	30	19		11
10 Jan 91	26	60	41	22		19
X	22.75	45.5	38	18.5		19.5
S	3.3	18.2	10.1	5.9		7.0

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Appendix G

Analysis of Administrative Chiefs' Meeting Minutes

<u>Date</u>	<u>Number Attending</u>	<u>Time</u>	<u>Issues Addressed</u>	<u>Addressed by:</u>	
				<u>DCA</u>	<u>Others</u>
16 Jan 90	18	55	51	22	29
30 Jan 90	17	70	61	A	61*
13 Feb 90	21	70	54	A	54*
27 Feb 90	16	40	30	A	30*
13 Mar 90	20	70	64	11	53
27 Mar 90	20	65	51	7	44
24 Apr 90	22	75	45	10	35
08 May 90	16	62	48	7	41
22 May 90	18	55	56	9	47
05 Jun 90	19	30	38	6	32
19 Jun 90	22	50	40	12	28
19 Jul 90	21	70	38	11	27
01 Aug 90	19	45	23	7	16
X	19.15	58.23	46.08	10.2	35.2
S	2.08	13.81	11.96	4.6	11.1
28 Aug 90	22	40	20	7	13
11 Sep 90	20	45	17	4	13
11 Oct 90	23	40	22	5	17
24 Oct 90	22	30	17	5	12
07 Nov 90	21	45	22	8	14
20 Nov 90	21	30	19	5	14
18 Dec 90	20	40	25	7	18
11 Jan 91	23	50	22	5	17
22 Jan 91	19	50	20	5	15
X	21.22	41.11	20.44	5.67	14.78
S	1.39	7.41	2.6	1.32	2.1

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Appendix H

Analysis of Quality Assurance Committee Minutes

<u>Date</u>	<u>Number Attending</u>	<u>Time</u>	<u>Issues Addressed</u>
22 Jan 90	21	70	12
22 Feb 90	18	30	18
22 Mar 90	13	30	6
19 Apr 90	18	65	15
17 May 90	17	40	6
21 Jun 90	14	30	4
19 Jul 90	17	30	3
X	16.86	42.14	7.29
S	2.67	17.76	4.46
23 Aug 90	16	15	8
20 Sep 90	19	30	8
18 Oct 90	18	30	4
20 Nov 90	14	30	2
17 Jan 91	20	30	3
X	17.4	27	5
S	2.4	6.71	2.83

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Appendix I

Analysis of Enlisted Troop Action Council Minutes

<u>Date</u>	<u>Number Attending</u>	<u>Issues Addressed</u>	<u>Time</u>
10 Apr 90	8	5	45
03 May 90	8	6	30
12 Jun 90	10	11	30
X	8.67	7.33	35
S	1.15	3.21	8.67
09 Oct 90	11	11	30
13 Nov 90	10	17	30
X	10.5	14	30
S	.71	4.24	0

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Appendix J

Analysis of Junior Enlisted Troop
Action Council Minutes

<u>Date</u>	<u>Number Attending</u>	<u>Issues Addressed</u>	<u>Time</u>
14 Mar 90	5	9	75
24 Apr 90	9	7	60
29 May 90	4	6	20
10 Jul 90	6	9	60
X	6	7.75	53.75
S	2.2	1.5	23.58
24 Sep 90	5	6	?
01 Oct 90	6	6	?
09 Oct 90	5	6	20
24 Oct 90	4	3	20
X	5	5.25	20
S	.82	1.5	0

Table 1

Interview Format Design

Interview format			
A	B	C	
Questions			Objectives
1,16	1,15,17	1,2,7,8	General feeling
2,3	2,3	3	Changes
4-8,13-15	4-8,14-16	4-6	Leadership
9-12	9-14,16	4,6	Communication
10-12	9-10	5	Innovation
7,8,10,12	5,7-10,12,	1,2,5	Participation
	15,16		

Objectives:

1. To get a general feel for the organization; its social system, formal arrangements, processes, and the attitudes of its employees.
2. To identify changes brought about by Desert Shield.
3. To identify and evaluate adaptive characteristics.

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Table 2

Stratification of Random Sample

Status	Duty		Totals
	Administrative	Clinical	
Officer	5	5	10
Enlisted	5	5	10
Civilian	5	5	10
Totals	15	15	30

Figure Caption

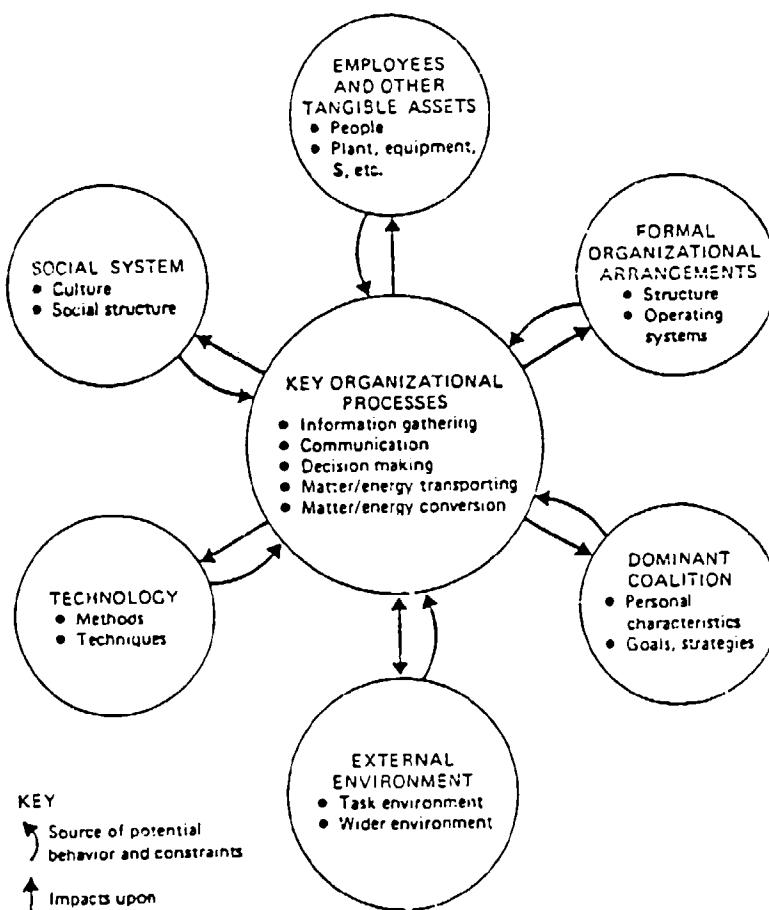
Figure 1. Model of short-run dynamics

Figure Caption

Figure 2. Model of moderate-run dynamics

